MANAGED HEALTH CARE IMPROVEMENT TASK FORCE

SPECIAL MEETING

TRANSCRIPT OF PROCEEDINGS

November 25, 1997

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Vice-Chairman

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Executive Director

ALICE M. SINGH
Deputy Director

MEMBERS:

Bernard Alpert, M.D.
Rodney Armstead, M.D.
Harry Christie
Nancy Farber
Jeanne Finberg
William Duffy, M.D. (appearing for Hon. Martin Gallegos, D.C.)
Bradley P. Gilbert, M.D.
Diane Griffiths
William Hauck
Mark Hiepler
Michael Karpf, M.D.
Peter Lee
J.D. Northway, M.D.
David Grant (appearing for Maryann O'Sullivan)
John Perez
John Ramey
Anthony Rodgers
Helen Rodriguez-Trias, M.D.
Les Schlaegel
Ellen Severoni
Bruce Spurlock, M.D.
David Tirapelle
Ronald Williams
Allan Zaremberg
Steven Zatkin

EX-OFFICIO:

Marjorie Berte
Michael Shapiro
David Werdegar, M.D.

REVISED WORKING AGENDA

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CHAIRMAN ENTHOVEN: Would the members please take their seats.

I want to welcome all of you and particularly express my appreciation to you for coming. I know that this is a considerable personal sacrifice for many of you to give up your other busy activities. I felt a number of members were kind enough to call me to say they felt we really had a very productive weekend. And the spirit got to be pretty positive and everybody got with the program, the idea of moving this along promptly, and I'm very appreciative of that. I want to thank you very much.

So as our quorum drips in, I guess we'll begin by asking Mr. Lawrence Ahn on the Task Force staff to call roll.

MR. AHN: Please indicate your presence by saying "Here."

(Roll call.)

CHAIRMAN ENTHOVEN: I'm going to call the Executive Director --

MS. SINGH: We do have a quorum.

DR. ROMERO: Thank you. I want to echo Chairman Enthoven's acknowledgment and gratitude for putting so much time into this. I just want to make one brief personnel announcement.

The Speaker of the Assembly yesterday -- or today, forgive me, appointed two alternate members

who are sitting at the table today. I would like you to raise your arm as I acknowledge you. David Grant is a staff member of Health Access and Consumer Advocates and Dr. William Duffy is a physician in private practice. Today, of course, we won't be taking any formal votes; so this won't matter for the purposes of today's meeting.

But just in general, it -- if I recall correctly, the bylaws specify that only permanently appointed members are authorized to vote in formal votes; is that correct?

MS. SINGH: That's correct.

DR. ROMERO: Again, this is an academic -- distinctive for today because any votes we take today will be straw votes. Today is devoted to paper discussion.

Thank you.

CHAIRMAN ENTHOVEN: Thank you very much, Phil.

Today's schedule is going to be on old business. We'll start promptly now. Unfortunately, Barbara Decker so far has not been able to be here. We intended to start with the Dispute Resolution process, which is a very important issue, but because Barbara hasn't appeared yet and she was the major presenter, I have decided what we should do is go ahead with the paper on the Practice of Medicine. Bruce or -- I saw -- where is Dr. Spurlock? Okay.

With your kind indulgence, I would like to see if we can do this within an hour. The outside limit at which we'll have to stop will be an hour and a half. Then we'll go serially through these papers with amounts of time usually reflecting the information that we got back from you in our DELFI (phonetic) surveys.

So this is going to require as the weekend did a great deal of discipline for people to limit themselves to those key points that they think are most important and not just have a more dispersive discussion. We will definitely stop at five o'clock. Whatever happens, that's been a commitment to a number of members who have planes and other things to catch; so we must move expeditiously.

So with that, we will take a break around 10:00. We will break for lunch around 12:30. And today members are on their own, but Alice will give you some recommendations or some information about where you might find lunch. I hope we can do that fairly quickly. And then after lunch we'll continue discussion and end by 5:00.

Let's see. All right. So we have essentially about seven hours in which to accomplish this. Now, I'd like to turn the meeting over to Drs. Spurlock and Alpert. If you care to open the discussion on your paper and then we'll move fairly quickly to the specific recommendations and walk through them. Thank you.

DR. ALPERT: Thank you, Mr. Chairman. We have a number of issues in this paper, and I actually think that it would -- may facilitate things in terms of time to jump to the recommendations.

CHAIRMAN ENTHOVEN: Alice, did you give this thing to the lowest bidder again?

(Laughter.)

DR. ALPERT: It's me. It's not the microphone.

I think it would be useful, because there is such an array of things in this paper, to go to the recommendations and concentrate the discussion there. There is an awful lot here. I think people know the background of this paper, I hope they do.

And with that, I would simply like to -- we can certainly, as we open things for discussion, entertain questions and have discussion about the background information also. Bruce and I are going to divide this. And actually some of this came from some other sources also. And I'm looking at the Chairman, do you want to -- if you want to change and go back, it's okay with me.

MR. LEE: Keep going. Let Barbara get settled in.

CHAIRMAN ENTHOVEN: Okay. We'll keep going.

DR. ALPERT: With that I would like to have you go to page 5 under Recommendation 1. And I'd

like to introduce the recommendation with a little background.

This entire recommendation deals with utilization monitoring or utilization scrutiny processes used in the managed care system. And in the interest of framing this in the snapshot view as to what's going on, where we were, where it is now, where it might go, I -- this area has some interesting factors.

The first thing that I think is interesting is the great positive. The great positive is that the processes that managed care has in some cases developed and in some cases simply taken on, the processes in support of it for utilization scrutiny and the organization of that, have produced great good in the system in terms of the quality of the management of care.

And I'm going to refer to those -- actually, I'll refer to them right now. And that is that -- multiple steps in the system: appropriate looking at whether or not utilization is being appropriate. Is it being overutilized? Is it being underutilized? Are the right protocols being followed?

The invoking of those principles has clearly been brought to health care delivery by managed care. And the -- a number of those involve looking at the system when the patient's not in the system. And those have great benefit because they don't interfere

directly with the course of a given patient's care.

And we've itemized all of those in the background. And they're actually included in the recommendations. And those things are things such as excellent pre-credentialed providers, proper outcomes based practice guidelines, clinical pathways, and appropriate retrospective utilization review.

So that if any utilization is -- falls out of a curve, you can find it immediately. And I always use the term how many hysterectomies are done or something like that. All of those fell out of the spectrum when a patient is being cared for. The one that falls in the spectrum when a patient is being cared for is we, for lack of a better word, describe it because it's commonly referred to as the pre-authorization phase or the concurrent authorization phase.

And that's the one phase that is triggered after a patient comes to a physician for a particular problem. And if we look at all of these areas -- all of these areas which are used and all which have been shown to managed care as credit, it could be effective.

And we then look at the reason this Task Force was convened, which is to find out why there is 7,000 calls a month basically to the DOC hotlines. That's simply a reflection of constituents meeting at a legislator's door which ultimately caused us to

convene.

And we try to impact that. You very clearly can point to one area as a large cost effect. And it was validated by the survey -- the results we were shown the other day -- and validated by the results that were brought in by Peter Lee. Peter will probably echo this later. And that is this pre-authorization phase as being a place where people are getting stuck in the system.

And what this recommendation needs to do is to take all the advantages of the good parts of the utilization monitoring processes that I've listed above that don't produce gumming up the works but do impact the public utilization and take out, to the extent that they can be officially taken out, the place that is where people are having trouble.

And the five recommendations that you see are something -- different ways in which to do that. What I'd like to do is give you a simple actual illustrative case that I think really makes the point, and then I'll go through the recommendation.

This is an actual case of an eight-year old child who presented to a major medical center in Los Angeles to be treated by the chairman of the Department of Pediatric Oncology. The child's diagnosis was Hodgkin's lymphoma. It was not in debate. The Chief of Pediatric Oncology decided to treat the child with radiation therapy.

The treatment was based on outcomes based data that has been presented in reams of literature for years. It was first really a national protocol, not controversial. Now, nobody could have been better pre-credentialed than this provider. This is a doctor pre-credentialed by everyone. The treatment is based on data from good outcomes.

All of the appropriate other review mechanisms can clearly identify that this is going to be appropriate. The process in the pre-authorization phase without casting any blame -- I can't imagine anybody who is trying not to have this child cared for -- resulted in the following scenario.

The first 10 days -- there was a telephone and a fax request. The first 10 days after 10 days of response was that the case was being still reviewed for medical necessity. After 30 days, the response from the carrier was the treatment was -- the decision was deferred. In 60 days it was denied. It was appealed by the Chairman of Oncology, Pediatric Oncology, and after three months it was approved.

Now, when I called the person -- the doctor involved and asked if this could have impacted on the patient's life, and she said, "Absolutely." Now, taking that case and putting it in the context, I want to look at the recommendations. And I'd like to start with Recommendation C. And I'd like to do C, D, and E -- that's the way they're listed here. And there

is a reason for that.

Recommendation C -- and I'm going to change some of the wording -- "the Task Force recommends to the Legislature and the Governor that they urge health plans and the designees to develop and implement strategies that allow providers demonstrating a gold standard range of practice to practice medicine with automatic approval."

Now insert "a probationary period of up to but not more than two years may be employed to assess provider utilization in determining eligibility for this automatic approval status."

That component is what was added by the doctor-patient relationship group. I believe Gil -- is Brad here? Yes. He just walked in.

Brad, were you able to hear the language that I just inserted?

It's essentially what Brad presented. So that there would be a two-year period where a plan can look at its providers and its credentialing to decide whether or not they would qualify, somebody that can give care when a patient walks in.

Now, we can train a person to be the anesthesiologist for two years; so I think that that's enough time to do this. The plan could decide to do it less if they want, but they certainly would have up to two years.

And then the final sentence in the

recommendation is "Health plans should develop appropriate and periodic review mechanisms to ensure providers continue to demonstrate a gold standard range of practice."

And what that does is it allows a periodic review by the plan to be sure that their physicians are fitting in that gold standard. We specifically did not say they have to do it after a year or two years or whatever because I think the plan can survive like that. So that's C.

I would like to present D and E in following to show how they dovetail. D is -- this will have different wording also -- "The Task Force recommends to the Governor and Legislature that the direct health plans and the designees eliminate prior authorization or concurrent review for patients with catastrophic conditions for" -- and I'm inserting language -- "for which outcomes based protocols have been developed and accepted, being treated by pre-credentialed providers," and then in parentheses, "(for example, pediatric oncology patients)."

And going back to the -- and I specifically would like to insert that as an example because I do believe that that is one group that it is very difficult to make an argument given the compelling nature of the needs of the group and the great risks of a process such as the one I described to you can impact the care of that child.

With all of the other mechanisms of utilization monitoring available, that is it not worth investing in that group to avoid something like what I just said happening, allowing that group and other -- and groups of patients with catastrophic conditions as long as there are outcomes based protocols that have been developed and accepted, determining that care by a pre-credentialed provider. So this immediately releases this pre-authorization phase for a certain group of patients with a compelling need.

Everyone else -- Hodgkin's lymphoma in an eight year old is different than a hernia. I don't have any problem if we want to wait two years and make sure the people who are going to treat those hernias are good enough in gold standard and so forth to go through that because of the common nature of the condition as such.

The last recommendation is "The task Force recommends to the Legislature that it bind" -- it says 2002. My inclination was to put 2000. I'm happy to hear what people want. This is a time constraint, and I would like to hear what the plans have to say in terms of what they think would be reasonable to do this.

That if by a certain date the private sector is not sufficiently known by this pre-authorization concurrent review process, to recognize gold standard range of care (inaudible).

That's the thrust of this.

The first two -- the first two you can read, we can talk about. Also, they're a bit more general. The first one has to do with a principle, and the way this was worded was actually it said, "The task Force recommends to major public and private purchasers." I actually envisioned this Task Force recommends to the government, government or legislature that they encourage health plans to incorporate these processes.

And if we use that, then we can also strike at the end of Recommendation A the words "contracts with health plans" at the end. And it will simply read "and outcomes based data into their utilization monitoring processes." That's simply a change of make a recommendation to the purchasers to get involved to put whatever is on the plans to use. I personally thought it would be more appropriate just to have -- recommend the plans incorporate these things and not get involved with the contracts, recommendations, and so forth.

And B simply is as stated, and that is the Task Force recommends to the health plans and groups (inaudible) designees, that they develop data to basically give them good ways to implement the utilization mechanisms that they already use.

I think they've already done that. I think we're actually in a place where enough of the

utilization scrutiny mechanisms have been brought and in play where you can now take out of the system one that we've identified by our research is producing a lot of the problems.

So that's a summary of that whole recommendation and is open for discussion.

CHAIRMAN ENTHOVEN: Could you walk us through the revised wording once more to make sure everybody has it starting with A.

DR. ALPERT: Sure.

"The Task Force recommends to the Governor and Legislature."

CHAIRMAN ENTHOVEN: That's on A?

DR. ALPERT: Yes.

"That they encourage health plans to incorporate" -- and then everything is exactly the same until you get to the end of the sentence. And in the last line of that where it says, "their contracts with health plans," I would strike "contracts with health plans" and have it read, "their utilization monitoring processes."

CHAIRMAN ENTHOVEN: Okay. Next one?

DR. ALPERT: The next one is the same.

CHAIRMAN ENTHOVEN: Okay. Third one.

DR. ALPERT: "Task Force recommends to the Legislature and Governor that they urge health plans and their designees to develop and implement strategies," and then that goes the same until the word

"approval" and then there is a period after "approval."

There's then a new sentence which says, "A probationary period of up to but not more than two years may be employed to assess providers' utilization in determining eligibility for automatic approval status." And that's the part that allows the plan to take the years to determine who they want to be a gold standard provider and who they don't. And then that's -- there are no more changes in C.

In D, "The Task Force recommends" -- and this is inserted -- "that the Governor and Legislature" -- and I have "direct." I don't know if people -- if they want to say "urge" or whatever, we can talk about that, but I have "direct health plans and their designees to eliminate prior authorization concurrent review for patients with catastrophic conditions" and then insert after "conditions," "for which outcomes based protocols have been developed and accepted, being treated by pre-credentialed providers."

And then I put the example, pediatric oncology, after that. It's a long sentence and if staff wants to come back and put some -- I don't have any objection to that as long as it doesn't change any attempt.

That -- then the last one is the same. I had written by the year 2000 instead of 2002. Again, I'm -- you know, if somebody wants to talk about that -- I'm interested in seeing how long people think

it would take to do this.

CHAIRMAN ENTHOVEN: Thank you.

Discussion.

DR. SPURLOCK: I'd like to make some comments, three quick comments.

CHAIRMAN ENTHOVEN: Sure. Spurlock.

DR. SPURLOCK: The overall thrust of this was to modify and to review the patient pre-authorization process. If a clinician does not meet a gold standard test, if they don't pass, they don't get the gold card. That's the whole assumption. We assume, then, that if you don't make the passing grade, you don't actually get to opt out or remodify from the prior authorization practice.

I would say this has been explained where it came from. Some of the language here, especially on the first recommendation, was a result of our DELFI process. This group thought that the (inaudible) appropriate place, but much of the language changed that on the thrust because of the overall direction.

A final thing would just be a point on why we think this is important. We think physicians should be able to earn the right to be able to have a gold card to be able to get out of this whole pre-authorization process.

And my analogy is that, if I were to go to my assistant and say, "If Chairman Enthoven calls, put the Chairman (inaudible)." That's because Chairman

Enthoven has developed the credentials appropriately to be able to access these correctly.

(Laughter.)

I think that's (inaudible) that right as well. So with the appropriate credential that meets the utilization requirement, they can actually bypass many of the steps and have direct access to those patients and direct ability to treat them according to their clinical judgment.

CHAIRMAN ENTHOVEN: Dr. Werdegar, Dr. David Werdegar.

DR. WERDEGAR: Thank you.

These are excellent recommendations. I support them fully. My comment is perhaps minor, but I wondered if the authors are wedded to the notion of gold standard in quotations. I really do think there are connotations to it which may be misconstrued unless a less colorful language that would say "properly credentialed based on peer reviewed retrospective utilization review," using terms of that sort. And that's not uncommon in hospital privileges and whatnot. I think this gold standard could be misconstrued.

CHAIRMAN ENTHOVEN: Well, it's taken in evaluation of diagnostic technologies, that hypothetical perfect diagnostic standard against which we compare all the imperfect things that we have. And you say you don't want to imply perfection here; right?

DR. WERDEGAR: I'm saying an ordinary

piece of card might do. You don't need the gold.

CHAIRMAN ENTHOVEN: Barbara Decker.

MS. DECKER: I also agree with the recommendations and intent. I just want to ask a couple of questions. I'm a little concerned because I just hear this. I don't know this. That's why I'm asking for information about the variation that's possible in protocols.

In other words, is the intent in C that, if a health plan has adopted a specific outcomes based protocol for X catastrophic condition, that that's -- it's a go but that could vary across health plans so it depends which health plan I have, whether -- if my child has this catastrophic condition, I have a gold card, pass?

DR. ALPERT: Bruce?

DR. SPURLOCK: I think the intent we're trying to get at is that the stakeholders involved accepted that process, and I think it has to be an action by the stakeholders, including health plans and medical groups, that this is really an accepted path or accepted protocol.

There are protocols of some institutions that are very experimental and wouldn't necessarily be accepted. But there are many protocols that are regional, like the Southwest Oncology Group is a good example, where they develop protocols where basically the rest of the nation accepts the protocol x, y, z to

z.

And once it's accepted throughout a broad group of stakeholders, including the plans -- and I would say it has to be a significant number of plans, that's the kind of thing we're talking about, well-accepted protocols that have been developed. And the Southwest Oncology Group is probably the best example of that.

DR. ALPERT: There is a reasonable test with regard to this. This language was added as we said to give some assurance to the stakeholders, to the plans, and so forth, that there wouldn't be (inaudible) leap through to do this.

On the other hand, there are enough already established ways to treat very significant conditions. There may be -- and cancer is one. There may be two choices of chemotherapeutic paths to take, but those are the two choices and then the percentage you could argue, one or other or the other. But if one of those two paths is chosen in a number of diseases, that will be acceptable.

The reality is I put specifically pediatric oncology in here to start with the absolute most compelling group where there was most to lose. And diseases like the oncology group where most -- the case I presented to you, the literature has supported this treatment for years. This is inexcusable.

Now, the reality is that in the State of

California, 57 percent of all adult cancers are in four groups: breast, prostate, colon and lung. Every one of those is being treated currently by national accepted outcomes databased protocol, by the National Cancer Center Network. And this is already established. The reality is that in most cases the same thing ought to apply. Now, the way this is written, I would assume that's the catastrophic condition.

DR. SPURLOCK: Barbara, my sense is that we're talking about areas where there is mentioned more certainty about the correct treatment pathway and not the areas where there is a great deal of uncertainty about the proper treatment pathway.

Many health plans and medical groups are already doing this. It's not something that would be key to stay in practice, but it gets on the table that these are the kinds of things we want to move forward to as much as possible so that we ask ourselves is this an uncertain procedure or protocol or is this one that we have broad agreement on.

MS. DECKER: I think your term "broad agreement," that these are the broadly accepted ones, we already have the volume of knowledge that we need to take hold and go forward with. I also just want to comment that I appreciate your change that you made in bullet A because I really do think that it's the plans that need to be the driver on this.

Certainly public purchasers and private purchasers are willing to take a position on this, but I think it's best left to the plans. This is better their role than our role. We can just make better requirement plans. So thank you for making that shift.

CHAIRMAN ENTHOVEN: We have a list now: Dr. Duffy, Dr. Gilbert, Mr. Zatkin, Dr. Rodriguez-Trias and Professor Enthoven. And if we're going to keep to 30-minute pieces for this, we have only about five or six minutes. I would ask people to make their intervention fairly concisely so we could go to the next one.

Dr. Duffy.

DR. DUFFY: Yes, sir.

I'm a spinal orthopedist and my comment of gold standards -- I ended up having to go to court about injuries. You said a gold standard on the list that somebody doesn't follow, you condemn that person as being (inaudible) probably will come in, put that in court as testimony, that you failed to follow the gold standard, the gold standard up here in my business of spinal problems when you order an MRI scan which is an expensive tool.

So I get a little concerned about a gold standard. It's fine for tumors but there are a lot of other treatment protocols I was worried about.

CHAIRMAN ENTHOVEN: Where the uncertainty is greater. Thank you.

Dr. Gilbert.

DR. GILBERT: Fee is talking about retrospectively reviewing UN referrals from the providers and determining that the basic referrals -- orthopedic, OB-GYN, et cetera -- meet within the health plan's guidelines for reasonable referrals, in other words, 90 percent of the referrals are approved or some number. So that's provider based.

I think the gold standard issue refers to the provider being retrospectively reviewed and approved to no longer have to go through the UN process. So I don't think it opens up the liability. I think we're mixing a little bit apples and oranges.

D, on the other hand, is talking about a member based change in review and structure where somebody who has a specific catastrophic condition and then the caveats of the particular protocols, which, actually, Barbara, that's more complicated than we think. (Inaudible) the accepted issue there is member based.

So, Dr. Duffy, I don't know -- maybe it was how it was presented, but the concept of the gold standard was not a standard of care. It was looking at UN referral retrospectively, determining the physician did it right and saying, "Okay. You don't want to go through the UN process." Is that --

DR. ALPERT: I didn't get a chance to respond to David's comment. I would accept that

totally as a friendly amendment. I don't know how Bruce feels. He had some different wording.

CHAIRMAN ENTHOVEN: Zatkin.

MR. ZATKIN: I think the model works well for plans such as Kaiser Permenante. I guess my question is whether it works for the broader networks. And from a public policy standpoint, the question is sort of balancing choice, having access to broader networks and how this would impact on those networks.

And I would ask that -- Bruce and Bernard, how you think it will and then maybe ask Maureen how those plans like Lifeguard will view this, whether they think it would work for broader networks.

DR. SPURLOCK: I'd like to respond to that. I think that the intent on this is sort of permissive language for the process. I think when you have networks that are based in the marketplace on (inaudible) and geographic (inaudible), it seems to strongly impact the size and makeup of the network.

What we're talking about, within that network there are probably physicians that need the standard. There may be physicians who don't need the standard. If you don't make the grade, you don't necessarily get out of the prior-authorization box.

Having talked with many medical groups and IPA's who have broad networks and not gone through pre-paid practice, about this preauthorization process, many of them have forgotten that whole process

completely because of the huge expense that entails.

What they have done, though, by the utilization review process to pick up the outliers is been able to more appropriately credential and counsel those outlier physicians. There's a huge concept of prior authorization. It's huge. And it's not dollars that are spent on the care of a patient. Many of the groups that have been -- gone that direction would wholeheartedly adopt it. I had my discussion with both members of NIPAK (phonetic) and members of the AMGA (phonetic) membership.

CHAIRMAN ENTHOVEN: Helen Rodriguez-Trias.

DR. RODRIGUEZ-TRIAS: My question was to the definition of catastrophic and how comfortable are you that that won't exclude a number of people? I'm thinking from the point of view of, say, children with chronic conditions such as seizure disorders and so on.

DR. ALPERT: I had initially written this for all pediatrics because I thought all pediatrics was compelling enough. And then for a number of -- so I agree with you. We're trying to take one step at a time. I would -- if everybody wants to include "all pediatrics," they have my blessing.

DR. NORTHWAY: So move.

DR. RODRIGUEZ-TRIAS: Second it.

(Laughter.)

DR. ALPERT: I take that as a friendly

amendment.

CHAIRMAN ENTHOVEN: Ron Williams.

MR. WILLIAMS: Several comments and actually a couple of questions. One of them is the direction of the proposal toward HMO versus PPO types of products and, again, this whole issue of things that will cause insurance-based products to more and more emulate HMO products and therefore end up with less product choice.

The other comment I would have is we have talked about preauthorization and concurrent review as if they're the same thing. And I'd be interested in teasing out if we could the distinctions between the groups behind preauthorization where we're talking about starting a course of treatment as opposed to concurrent review regarding treatment. I think overall the goals are good. Clearly I think there are opportunities for improvement in this area.

A couple of other things I would comment on is that -- to go back to the RAND study, I think it's important that we recognize that the research demonstrates that 30 percent of all procedures are necessary. That's RAND's finding.

I think clearly we must improve the process, but we also need to be certain that we have the data system necessary to accomplish this. And the variability just on the basis of studies being done in the Los Angeles area, it turns out to be a great deal

of variability and even a difference, as I understand it, between the specialty society depending upon (inaudible), what's the right frequency of certain kinds of (inaudible).

So I think one of the questions is whose protocol and whose standard? Which specialty society? Is it the health plan? Medical group? IPA? And how does the individual physician figure that out? Which standard are they being asked to apply, the specialty society or which?

I think that a recommendation that I would be personally more comfortable with is a recommendation that basically says we ought to come to some standards for pre-authorization review, that we need a process of making those decisions. Fundamentally they're coverage decisions. They're decisions about what's covered under the health plan, and we keep coming back to this point.

It's a decision about is this a covered service under the health plan that was purchased by the employer? And that sometimes is a different decision than clinical appropriateness of the treatment (inaudible). So I think those would pretty much be my comments. I would be interested in a response.

DR. ALPERT: Starting at the end and trying to go back as far as I can remember, the coverage treatment debate is one that will go on for a long time. Actually, the fourth recommendation with

regard to the language is aimed at that. It's to try to demystify that because that's an area that right now has to be debated in courts sometimes and sometimes it can't be debated in courts. It's a subject of debate.

If we had very clear delineations -- at any given issue, I don't have a problem with it. If our transplants are not covered and someone needs a heart transplant, then it's not covered. If heart disease is covered and then a decision is made as to whether or not somebody needs a heart transplant or not, that's a medical debate. We are not the court of last resort to decide some of the things that happen.

The recommendations -- in the interest of brevity, the recommendations were carefully developed, and that's why there are five. To try to take into account most of the other concerns, that's why the two-year probationary period was put there for the issues of other than the absolute most compelling populations.

It's why the -- it wasn't immediate for everything and there is no mandate up until a few years. That's why I was asking for advice as to 2000, 2001, whenever. So we're trying to build in this versatility. The reality is this area has been earmarked as a massive source of problems in the system.

CHAIRMAN ENTHOVEN: I think by implication Ron was offering a friendly amendment

that -- recognizing that prior authorization and concurrent review are very two different things, and he was offering a friendly amendment that we take out "concurrent review."

Do you accept that as friendly or should we --

DR. ALPERT: If it produces a loophole to allow what's happening now to continue to go on, then, no. If --

CHAIRMAN ENTHOVEN: This is once the patient has been operated on and now they're in the hospital, a concurrent review is --

DR. SPURLOCK: I think they're separate issues, but the principle should be the same. If they're in the hospital and you've already sort of proven them (inaudible) x, y, z to z's, then you've been pre-authorized to do the procedures.

I'd like to really quickly address two of Ron's points. I think the issue about the PPO versus the HMO, it's interesting to me that many HMO's that have capitated providers, they actually don't have access to be able to do this. This has to be done in the medical group or IPA level.

Those that have claims based, while a claim is not good, entire data is good. (Inaudible) actually have the ability to do this with outcomes using those encounter data (inaudible). So I don't think it necessarily forces a PPO to an HMO.

As far as the coverage decision, I think it's a very good distinction to make. I would say that the principle (inaudible) could apply in that resort. Physicians who have practiced in such a way (inaudible) this group of patients, so if I'm in x, y, z health plan and I know they don't cover this certain procedure and I've never authorized that or never done that, that there should be some (inaudible) utilization pattern.

I don't think it necessarily says we're always up against the coverage decision. If a physician has demonstrated their practice pattern, they're not up against the coverage decision but they're in that care of patient.

DR. ALPERT: With regard to that, in the case I presented where the patient's at the pediatric oncologist, that could easily be viewed as this is concurrent review because now the patient is at the oncologist's office and now we'll review the recommendation (inaudible).

CHAIRMAN ENTHOVEN: I'm going to call on myself now, just a few very quick comments.

The first, I agree with Ron, that it seems to me you need to have encounter data first. One of the problems is the HMOs just can't do this now because they don't have the encounter data which seemed like this ought to be qualified for that. But until they get counterdata, they have until the end of a statistical basis to do it.

Secondly, one excellent HMO, pioneer HMO with which I'm well acquainted, when it comes to CABG's, for example, they have a kind of cardiology review board, and before a case goes to surgery, the case is presented and debated by a group of cardiologists and surgeons and so forth in order to get a group opinion on it. And I hope that we wouldn't somehow be trying to outlaw that because that's like not only a second opinion, you're getting a multiple opinion, but I hope we wouldn't be outlawing that in this process.

DR. ALPERT: I don't personally see this as outlawing exactly what you've said. What you've said I heard is somebody with a heart disease that it has been suggested that they have heart surgery and cardiologists and heart surgeons opining on that.

CHAIRMAN ENTHOVEN: Right.

DR. ALPERT: If it took three months or something for that to happen, then --

DR. SPURLOCK: It would happen if we preauthorize that committee process. I see that happening in many, many cardiology groups. So again, the whole notion is that that could be the component that then goes ahead with authorization.

CHAIRMAN ENTHOVEN: Somebody could interpret that as prior authorization, but you wouldn't.

Are you going to comment, J.D.?

DR. NORTHWAY: I want to comment on the first one. Because someone doesn't have the data, I'm not sure it gives them the right to say, "No."

CHAIRMAN ENTHOVEN: But it doesn't -- but it may not give the right to -- they just don't have the basis for a gold card or visa card.

DR. SPURLOCK: We have a lot of utilization data. In fact, many of the medical groups, as I said earlier, have forgone prior authorization once they've been capitated simply because they have the provision to be able to do those things.

CHAIRMAN ENTHOVEN: But I understand from the carrier HMOs that many of them get little or no encounter data from any of their groups.

Next point just quickly --

MR. ZATKIN: Did you get an answer to the question about the group review?

CHAIRMAN ENTHOVEN: Well, maybe in the working out of wording then we'll do something to make clear that we're not talking about established review committees.

DR. ALPERT: I agree that there could be some working out from there. I see this as a first step and then there are lots of places here, i.e., the two years, not only the two-year probationary period but the years before this has to be implemented. There is some big time frame in here for this to be worked out.

CHAIRMAN ENTHOVEN: So if this medical group happens to establish a cardiology review committee, that's not going to be outlawed?

DR. ALPERT: I'll just take that specifically. In the period of time between let's say the Legislature says this is a good idea and there is still nothing mandated and so in this two-year period or three-year period, whatever it is, of working out how it's going to be done, the incorporation that has been established is excellent. It would easily fit into the --

CHAIRMAN ENTHOVEN: Okay.

DR. ALPERT: -- plans.

DR. SPURLOCK: Essentially it's a guideline. If the cardiologist went through a group and was thumbs out that there would be no further prior authorization (inaudible), I think -- or it won't happen necessarily beforehand.

CHAIRMAN ENTHOVEN: A quick comment. I do believe in my honest judgment that this would substantially shift the competitive positions between prepaid prepractice and individual practice based plans. So if you want that to happen, I think that's a consequence. I think it would be a lot harder for health plans and others compared to prepaid prepractice.

DR. NORTHWAY: Could you amplify that a little bit. I'm not sure I understood what you said.

CHAIRMAN ENTHOVEN: Well, again, one of the large established pioneering prepaid prepractices that we're not supposed to mention doesn't do prior authorization because they select their doctors very carefully. They do all the good things you talked about. Retrospectively they feed doctors how they're doing against norms in a professional supported way.

But when you get to HMOs that depend on physicians in individual practice, they do rely much more heavily on things like prior authorization as we heard from Dr. Aieda (phonetic) of Lifeguard. Although Dr. Aieda gold cards some physicians for some practices, I doubt that it's some physicians for all practices. In many cases they do use prior authorizations.

So all I'm saying is you will damage their competitive position because you will weaken one of their most important utilization management tools. So feel free to support me if you want.

DR. ALPERT: I disagree. I think that the system -- that, if they show that kind of excellence, there's a plumbing of leeway for them to demonstrate that and to incorporate that into the plans to present to the Legislature that this is what we're doing.

CHAIRMAN ENTHOVEN: The fourth comment, briefly, I think about -- I wondered how it will play against something like the Kriski (phonetic) case.

Because the conventionalism here is a good thing is when the good doctors do the right thing which they always do and to prevent the evil HMO from reaching in and messing that up.

Harry and I were talking before the meeting, I was congratulating him on his appearance in the "Wall Street Journal" and saying unfortunately this is a case in which a prestigious medical group was determined to do the wrong thing.

And the fault was that the HMO didn't reach in and tell him, "You can't do that. We're going to insist you do it differently"; that is, how a clinic wanted to use a urologist who had not operated on children and what needed to have been done is to get in and say, "No, we're going to make you refer this to proficient physicians."

So I want to be careful to recognize that sometimes HMOs have a legitimate function to reach in to make the right thing be done.

DR. ALPERT: I think everything you say is true. I don't think it --

CHAIRMAN ENTHOVEN: We really have to move to vote on this because we're -- our time is getting to be faint. Do you want to vote on this --

MS. FARBER: I want to say something. The discussion that you were having around whether or not an HMO issued gold card would preclude the normal utilization review and quality assurance activities

that occurred within a medical group or a hospital medical center need to be reassured that they don't and that hospitals and medical groups never substitute the judgment of the HMO and their mandates (inaudible). It's a very serious responsibility to do this according to the standards of practice in their community.

CHAIRMAN ENTHOVEN: Thank you.

All right. Do you want to vote on all of one or one A, B, C? I mean, these are straw polls to get the sense of the --

DR. ALPERT: It doesn't matter to me.

CHAIRMAN ENTHOVEN: How should we --

MR. LEE: Why don't you run through each of them very quickly.

CHAIRMAN ENTHOVEN: Should we run through them?

MR. LEE: Yes

CHAIRMAN ENTHOVEN: One, a Task Force --

MR. LEE: We don't need to read them unless people need that.

CHAIRMAN ENTHOVEN: 1A, all in favor.

(Committee voting.)

CHAIRMAN ENTHOVEN: All opposed.

(Committee voting.)

MR. LEE: Could you call the number out. How many voted for that?

CHAIRMAN ENTHOVEN: 14.

I understand we're not counting the

people who are not actual members. We're trying to get a feel for the voting members at the end.

Secondly --

MS. GRIFFITHS: Mr. Chairman, could I pose a question?

CHAIRMAN ENTHOVEN: Yes.

MS. GRIFFITHS: My understanding was with the straw votes that the alternates could vote. That was our purpose in having them here. We carefully chose alternates who share the views of the people who they're sitting in for.

DR. ROMERO: We never formalized this, but I don't have any disagreement with that.

MS. GRIFFITHS: That's why we carefully chose --

MR. WILLIAMS: I would respectfully disagree with you. If you don't have an alternate --

MR. LEE: If I may, the main reason that we're having a straw vote is to see what comes back in a formal vote. I think everybody would agree without doing that, this will come back for a formal vote. There's not very strong opposition; so in this situation, it doesn't matter. If we get to something where it's seven and seven, we can talk about it. In this circumstance, unless you think this shouldn't come back --

MR. WILLIAMS: I think we should use a level playing field for all Task Force members. If

they can't come, they get to influence the process through an alternate versus those who don't have an alternate.

MR. PEREZ: I think we need to clarify this issue now because this is an issue that it's clear that the votes of the alternates are not going to make a big difference instead of coming back at a point where those votes are going to make a difference and have our decision based on whether or not we like the vote of the alternate.

We should really just clarify it right now. And I'd ask that the Chair count the votes of the alternates. Obviously they're not binding votes. We'll come back and take binding votes later. It gives us a sense of where we are and where the alternates are coming from, representing the folks who couldn't be here today.

CHAIRMAN ENTHOVEN: All right. Fine. Done.

With that, 1B read, 1B as modified.

All in favor?

(Committee voting.)

We have a majority. Done.

1C. These are with the amendments that have been discussed, of course, which we've had read back to us.

Those in favor?

(Committee voting.)

We have a majority.

1D. Those in favor.

(Committee voting.)

Majority in favor.

And 1E, those in favor.

(Committee voting.)

Okay. Majority.

We'll move on to Recommendation 2.

DR. SPURLOCK: Thank you, Mr. Chairman.

I wanted to make a preface on Recommendation 2. This issue came from outside our ERG and then was subsequently discussed within our ERG to make sure we deal with the situation.

As you can see, the first recommendation attempts to help medical groups that have 15 or more formularies by which they have to (inaudible) prescribe for their patients. I have many colleagues who do do that. It's hard to know (inaudible) when they leave the office and what it does is it creates huge amounts of paperwork and huge amounts of time constraints that take away from actually caring for patients because you have to always be on the phone to find out if this is the formulary for that patient.

More importantly, I want to make a general comment on formularies in general because this issue is so important. A formulary in its most basic sense is nothing but a guideline. It really is just a guideline in the pharmaceutical area.

Part of the reason the guideline was developed is because the FDA approves what's called Category 3b drugs. Those are drugs that (inaudible) with no clinically significant or any difference between the compounds. And as Phil Romero would say, this is like a substitute.

So for many, many drugs, there are (inaudible) components to them that can actually safely use the distinguished (inaudible) accept one different formulary for the various categories of drugs. The whole idea behind recommendation C was to streamline the process at the treatment level, not necessarily simplify the process (inaudible) but simplify the process for the patient and the physician (inaudible) when they're trying to decide which drug makes the most sense for their clinical condition.

I would say that we need to add in here some language that Peter Lee and I talked about that we would add on the second line. I'll read it from the beginning, "Health plans should permit medical groups or groups of -- groups capable of (inaudible)," and then insert "clinical management."

And what this is attempting to ensure is that you don't have five personal groups coming up formulating on their own. You actually have a process and clinical justification for how the formula is developed among the medical group. And the process should be one that is accepted, and we'll talk about

that in a minute.

In addition, the same clinical language that we added to the second to the last line in Recommendation A, so if the last line reads, "A (inaudible) should oversee the medical group's clinical administrative and financial capacity for managing the pharmacy benefit."

Basically there's an oversight to make sure that, in fact, medical groups are using a process. That's why they accepted this permanent formulary. They're not making fly-by-night guidelines in order to stay on top. In fact, they considered all the clinical ramifications.

On the notion of one guideline fits all, I think it's clear that, to develop guidelines, that there are many ways to skin a cat in many clinical situations. So what makes the most sense is that a group (inaudible) they have all the input in how those guidelines are developed. That doesn't mean you can't use different drugs or different processes to accomplish the same end.

In the medical practice, we have a significant amount of overlap and a certain amount of uncertainty about which way is the best. If there is one that clearly demonstrates the most effective use of a pharmaceutical, then that data should obviously be used. Absent that data, we want to have the flexibility in the process at the medical group level.

The second recommendation is basically to make sure that the product (inaudible). We want to make sure that the process includes the sense from the practicing plan group, and the people actually have to employ it when health plans make formularies outside the medical group process. Peter Lee substituted (inaudible) for all of us, and I can agree with most of the recommendations. I would make minor modifications, and I don't have that paper in front of me now.

I would say, Recommendation A, that the publishing of the formulas have been periodic and we can't constantly publish a process because it's so intensive when drugs are -- they come off and on very quickly. A good example of that is Quinine, the drug taken off the market. Six months later it was put back on the market. You used to be able to buy Quinine over the counter. Because of the problem with leukemia, it was taken off the market. After further review, it was put back on the market.

And the last one, the language, "When a health plan removes the drug from the formula, it must allow the patient to continue (inaudible) ongoing condition unless the treating physician prescribes the patient a new agent."

And basically I think that gets out what Peter is talking about in the parentheses part. I don't think that "inappropriate" is the right word. (Inaudible.)

And the rest -- I can discuss the rest of the recommendations on the formal issue that Peter addressed to the Task Force.

CHAIRMAN ENTHOVEN: Let's see, Bruce, could we just get the wording changes exactly.

You don't change in A?

DR. SPURLOCK: All I add is "must periodically publish."

CHAIRMAN ENTHOVEN: Okay. Thank you.

DR. SPURLOCK: On the last I would just delete the parentheses, and I would say "unless the pretreating physician changes the prescription."

CHAIRMAN ENTHOVEN: That's on the last one?

MR. LEE: No. D. Second to the last one.

DR. SPURLOCK: This --

CHAIRMAN ENTHOVEN: I want to just get the words here for the purpose of the scribe.

(Reviewing document.)

Unless --

DR. SPURLOCK: Unless the treating physician changes the prescription.

MR. LEE: Al, as much as we've all got a copy of the paper, some of the members don't have this in front of them. I didn't bring another extra set of copies. If I could help, I could walk you briefly without reading verbatim the main points, then I

recommend we add in front of the two recommendations that are part of this ERG. Is that okay?

MS. GRIFFITHS: Mr. Chairman, I would appreciate that. I don't have a document being referred to and I think several other people don't as well. I'm having a difficult time following.

CHAIRMAN ENTHOVEN: I am, too.

Peter, I guess you need to read this for the record.

MR. LEE: The background is formulary prescription issues are one of the major issues of confusion that consumers have. And it's also an issue with health plans and other groups that (inaudible), and I think there is some agreement on what might need to be done. I thought it would be very helpful for the Task Force to acknowledge what we heard in public testimony and recently seen concerning consumers as a major issue of confusion and problem.

I recommend it be inserted in front of Recommendation 2A are the following, "The Governor and the Legislature should ensure that consumers are fully informed of their rights to prescription drugs offered by health plans and those rights should include but not be limited to the following."

First, "all health plans that offer prescription drug benefits and use a formulary and their designees, whether pharmaceutical benefit managers or medical groups, must periodically publish

their formulary list and make them available to any member of the public upon request."

"B. All health plans that offer prescription drug benefits and use a formulary and their designees, et cetera, must publish the process by which the formulary is developed and reviewed. Health plans and their designees whether managers or medical groups must have in place and make known to consumers commonly accepted (inaudible) by which physicians and patients -- and patients may get quick approval for medically necessary non-formulary drugs."

"D. When a health plan removes the drug from the formulary, they must allow the patient to continue receiving the removed drug for an ongoing condition," and this is what Bruce amended this to read, "unless the treating physician" --

DR. SPURLOCK: -- "changes the prescription."

MR. LEE: -- "changes the prescription."

CHAIRMAN ENTHOVEN: And take out the rest of that about unsafe?

MR. LEE: Right. And the final is "the agency responsible for regulated health plans should be directed to periodically investigate and publish a report on health plans contracted medical groups' compliance with these recommendations.

CHAIRMAN ENTHOVEN: In the interest of time, I'd like to without objection be able to manage

the discussion by asking, if a couple of members are particularly opposed, to let them have their day in court and then try to move this quickly to a vote.

Brad?

DR. GILBERT: I'm actually in support of all of Peter.'s I have one question when you say in number --

CHAIRMAN ENTHOVEN: I was asking for who were opposed.

DR. GILBERT: I'm opposed to 2A. I need a clarification on this. I'm opposed to 2A.

Peter, physicians and patients may secure quick approval that the prescription is done by the providers; so the patient on there would need to (inaudible). The objection I have to 2A is the bad decisions that have been made around --

MR. LEE: You're talking about the 2A here?

DR. GILBERT: Yes. The bad decisions that I think have been made around pharmaceuticals are economic ones, whether it's some benefit to the entities applying for medication. From a financial benefit, they're not to put medication A on but put medication B on even if A is, in fact, the most therapeutic and potentially the most cost-effective if you don't include rebates or discounts.

My concern about medical groups, bringing it down to the medical group level, is that same

economic pressure could, in fact, be worse in some ways because there would be direct economic benefit and two individuals who own that corporation (inaudible).

So I think we can use Peter's outline to structure the process to make sure the formularies are created appropriately and that there's a quick acceptability to get exception for medically necessary drugs. And I would just agree with getting that down to the medical group in terms of them being able to set their own formula.

CHAIRMAN ENTHOVEN: Nancy?

MS. FARBER: I would like to offer a suggestion to B on Peter's paper that not only must they publish the process by which the formulary is developed and reviewed but also disclose when substantial discounts have been given to the health plan that are not passed on to the physician group that has to manage the risk.

DR. DUFFY: They should also let you know who's on the committee. Because "Dateline" currently interviewed me just like Jim Leary spoke to Dr. Gallegos last week. My patient wouldn't go. They were very interested in this issue. It's a very hot issue in the country at the present time. And my patient tried to get who restricted the drugs, and they would not tell her in the HMO.

CHAIRMAN ENTHOVEN: On the question of disclosure, you're going to run into the whole question

of proprietary business information, and pharmaceutical companies will be a lot harder to persuade the discount if they have to disclose it as part of an interest in an individual deal. If the medical group is at risk, then of course presumably the medical group takes the --

MS. FARBER: No. That's not what's currently happening now. A lot of the reasons why pharmaceuticals are the hardest part for physician groups at risk to manage the expense and the area in which they routinely exceed their (inaudible) is because the formulary was stipulated by the health plan who enjoys a discount that is not passed on to the medical group under the premise that this would be a kickback.

CHAIRMAN ENTHOVEN: Oh. That's an interesting -- I see. Nancy is raising a point -- you mean legally if the medical group created the formulary --

MS. FARBER: No. The health plan stipulates to the formulary in some instances.

CHAIRMAN ENTHOVEN: Let's talk about the case proposed here in Recommendation 2A. Let's say a group of -- let's say AMGA, for example, said to me they would like to create their own -- the medical group in California named AMGA would like to create their own formulary and all their medical groups would use it, then they would negotiate it and presumably

they would get the discount.

MS. FARBER: Well, if they're at risk, I mean, sway the discount. That's fine. The portion of this bothering me is when the health plan negotiates with a pharmaceutical house, stipulates their drug.

CHAIRMAN ENTHOVEN: The intent of 2A is to get it to be what you called just fine, that is, the medical groups do it and they would get the discount.

MS. FARBER: Would they routinely get the discounts and this would then prohibit plans from taking money from the pharmaceutical company? I don't think that's what that says.

CHAIRMAN ENTHOVEN: Well, if they developed their own formulary, then they're in a position to negotiate for discounts. If they developed a formulary, the health plan in that case would not be in a position to negotiate for discounts because they wouldn't be controlling it anymore. It's implicit in it, but if it would improve from your point of view, it could be made explicit.

MS. FARBER: I would like it made explicit. It would improve it from my point of view.

CHAIRMAN ENTHOVEN: Okay. Including discounts. Health plans should permit medical groups or groups capable of consuming management financial risk for drug formulary to retain the decision making authority for their patients and to receive -- and to negotiate discounts and -- received discounts.

Is there any objection to that? Is that a friendly amendment? I had understood this was implicit in it. Now we'll get on to the merits.

Ron.

MR. WILLIAMS: Let me first agree with everything that was said earlier, Brad, about the inherent conflict with physicians. I think this would be a tremendous conflict. I think -- I would also say I think Peter's recommendations in his A through E also (inaudible) we ought to do or be supportive of.

I think in the original recommendations, I think that 2E is not something I think we would be supportive of or the industry as a whole. 2A is not something that we or the industry would be supportive of. When we have to file or file with our regulator, we have to say, "What's in the formulary? How does it work?"

If the formulary is opposed of their amalgamation of 150 different medical groups' formularies, how do you say to a member under any circumstance what is it they are buying in the way of access to a very important benefit?

I think the process of developing the formulary would require substantial critical input. I think all (inaudible) who participate is perfectly acceptable assuming there isn't some peer review confidentiality issues.

But I think that the concept that a

health plan would have a formulary oppose or whatever formulary 150 different medical groups, it would be an untenable kind of situation, the point of view of what you take to a customer, let's say to a market, let's say to a vendor, this is the kind of quality (inaudible).

And I appreciate Nancy's comments. But I think, with everything that's negotiated, there is a proprietary fee schedule associated with it. There are bill charges and then a discount off the bill charges, whether that's negotiations with the hospital, negotiations with the physicians or negotiations with the pharmaceutical companies.

MS. FARBER: I'm not suggesting that the amount of discount fee occur, just that it has occurred.

DR. SPURLOCK: I just want to respond to the notion that there are 150 different medical groups making out formularies for that year. It seems -- I have some cognitive dissidence on this idea that health plans sell pharmacy benefits. If they're actually going to sell an individual treating pharmaceuticals, many times we don't do treatment decisions, we just do coverage decisions.

And even though the pharmaceutical decision is a treatment decision that the individual physician makes, it seems like there is something not resonating in my head. On the one hand you say that

and so on the other hand you say (inaudible).

I think the idea here is to keep it at the treatment level and that, if you're selling something to the public, what you're selling is a pharmacy benefit that appropriately treats your pharmaceutical and that need.

And that those needs are determined at the treatment level by the group of people that are doing that. There are 50 different ways to make pharmaceutical decisions. The best example is the non-steroidal category. There are about 20 different non-steroidal anti-inflammatory drugs that have marginal, if any, difference between them.

To say that one group has you use this drug and another health plan says you have to use this group, it's only because they've been able to negotiate discounts on those drugs because they're like substitutes. It seems crazy.

The medical group should not be able to do that and see the things that Nancy talked about, being able to negotiate like (inaudible). Because that's, in fact, what they are. We can have problems with other category drugs. There are lots of mistakes. It's not independent of the medical group or the health plan making those bad decisions.

MR. WILLIAMS: They can always dispense it.

CHAIRMAN ENTHOVEN: Michael Shapiro.

MR. SHAPIRO: We've had oversight hearings on this issue for two years. The items in Peter's list have reached consensus at least among the stakeholders and Legislature including the health plan industry has endorsed those.

2A is very controversial. I've sent material to the staff including "Wall Street Journal" articles, "Sacramento Bee" articles. We have a complaint received from Consumers of Quality Care because most of the medical groups are incapable of dealing with the clinical issues involving formularies. Those that have been delegated have been highly criticized and, in effect, the plans have been criticized.

For medical groups, their formulary is red light, green light because they're budget incapitated and they have -- they do not use P and T committees, pharmaceutical -- the committees that look at outcome performance. They're unfortunately driven by economic pressure and they're not there yet.

So my biggest concern with A is the limited discussion of the clinical issue that needs to be overseen by the regulator and that the health plans need to worry about -- because you're held accountable for the medical groups. The complaint you have in your document from Consumers on Quality Care are formularies that are much more restrictive than the plan's formularies because the plans have cut the discounts,

the plans have got the resources.

They have, even though they're criticized, fairly broad formularies. They're now getting oversight to the P and T committees. The medical groups under a budget have been limiting access to drugs that are on the plans' formularies because they do not have the benefits currently that the plans have.

Until you can deal with all the issues, you run the risk of medical groups who are under financial pressure, making formulary decisions without the benefit of clinical outcome oversight of P and T committees and actually restricting formularies that are otherwise broader than the plans negotiated. I'm not saying it can't be done, but it's a controversy that we have not yet been able to resolve in the consumer's interest.

Now, the related problem of medical groups having 15 formularies is a serious one, but the answer may not be to let them do their own formulary until we determine that we can deal with the clinical issues, the P and T committee oversight and other things that only the very largest medical groups are capable of doing.

So I just put a red flag out there that the one addition of the term "clinical" with the absence -- the plans now have to use P and T committees for the most part. Those P and T committees -- and

each of their decisions is scrutinized when they're pending legislation that I need to see in the legislative oversight equal scrutiny of medical groups using those P and T committees, getting that oversight by the regulator before there would be assurance by the consumers that are calling up because they're cut off from drugs that these were decisions made based on medical efficacy and not money.

This is a very controversial issue. The plans will suffer if the medical groups don't do a good job.

CHAIRMAN ENTHOVEN: Thank you.

Diane Griffiths.

MS. GRIFFITHS: Much of my concern has been expressed by Ron and Michael. I have a serious concern about the administrative capacity of multiple medical groups to adopt their own formularies. To the extent it causes a lot of problems with patients, the proliferation of the formularies is not the way to go.

I would be reluctant to support the recommendation as stated. But the proponents of it raised some interesting issues, and I would propose something along the lines of a pilot project look at it closely, but I couldn't support the full-blown recommendation at this time.

CHAIRMAN ENTHOVEN: It's really very difficult for me to express agreement with Michael, but while my heart and my economic intuition is in favor of

the physicians who are treating the patients being the ones who make the decisions because it's a chosen and effective drug, they've got that patient back in their office the next day saying, "Doctor, you didn't cure me."

But I think what Michael is saying has a lot of truth. We aren't opposed to other medical groups being able to do what the Permanente medical groups do because -- or they have the resources to have P and T committees that do all the research and everything else.

I'd like to be see if we can start taking straw votes. May I put before the house first the modified version of Peter Lee's -- as modified in discussion --

VICE CHAIRMAN KERR: I was going to move that we replace the paper's 2A with Peter's A through E.

MR. LEE: I think the 2A as there, since we aren't voting formerly, I'd suggest to vote on the blanket of my A through E first and then do a separate on the other. That will sort of mix them up. I don't think we need to -- my guess is to go through A through E. I don't think we need to go through the specifics of the A through I. I suggest we go --

CHAIRMAN ENTHOVEN: The Chairman is going to wield his arbitrary authority and say we're going to vote first on just the adoption of Peter Lee's package

as modified. All in favor, raise their right hand.

(Committee voting.)

Thank you. That's been the majority.

Secondly, then, we will take a straw vote on -- well, let's put it as all in favor of keeping recommendations 2A and B as -- with the Nancy Farber modification to negotiate received discounts with groups' clinical administrative and financial capacity.

With those modifications, all in favor, please raise your right hand.

MS. FARBER: I didn't understand.

CHAIRMAN ENTHOVEN: The recommendations as in the original paper, 2A and two B, 2A would be revised at the end of the first sentence to add "and to negotiate received discounts." The last sentence would be revised to read "the lead HMO regulatory agency should oversee the medical group's clinical administrative and financial capacity and ability to bear the financial risks for managing the pharmacy benefit."

These go together. So all in favor of that package of recommendations, please raise your right hand.

MS. FARBER: I think there is some confusion about where I intended my amendment to be placed.

CHAIRMAN ENTHOVEN: Nancy, what I understood is you want it to say if the medical groups

do assume financial risk to create a formulary, then -- and negotiate drugs, then they would be ones who would receive the discounts.

MS. FARBER: I guess I assumed and should have clarified that amendment would have appeared in Peter's paper under B.

CHAIRMAN ENTHOVEN: Oh.

MS. FARBER: Perhaps --

CHAIRMAN ENTHOVEN: Let me just read it (reviewing document).

MS. FARBER: Then it would be an addition or modification to be in Peter's paper dated November 19.

CHAIRMAN ENTHOVEN: Peter's paper under B talks about publishing the process by which their formularies are developed and reviewed.

MS. FARBER: What I asked for is to be included in disclosure --

CHAIRMAN ENTHOVEN: Oh. Plus disclosure discounts.

MS. FARBER: Not the dollar amount, just that that has occurred. I think the physician groups have to know, when they're managing a formulary, that they're mandated by a health plan and they have to take (inaudible) discount has been taken up front by the health plan. They have to know that or they can't manage their --

CHAIRMAN ENTHOVEN: Okay. Let me -- I

want to ask for a straw vote. Going back to Peter Lee's November 19th memo, Item B, the Farber amendment would add at the end of Item B "and disclosure of existence of discounts but not the dollar amounts."

All in favor, please raise your right hand.

(Committee voting.)

All opposed?

(Committee voting.)

There was eleven to nine in favor of adding those words, but it's still not a majority.

MR. PEREZ: Mr. Chairman, some of us -- I for one didn't vote on that. I came in partway through some of the conversation. I didn't feel comfortable. I wouldn't want my lack of voting to be seen as opposition to it.

MR. LEE: Could I suggest that that issue be -- Nancy be prepared to bring that back at the next meeting to add it again? It was sort of a split at this point. At the next meeting, we'll actually get a final to consider it and if there's information that could inform us on that vote better between now and then, I certainly welcome that.

MS. FARBER: Peter, what are you asking me to do?

MR. LEE: That what is carried through is the unamended language and you're welcome to and I encourage you to bring it up again at the next meeting,

to add your language again for a formal vote, that if you have information that could convince those of us that vote for it or are uncertain about these issues, let us know.

MS. FARBER: I listened with great care to what Michael wanted to say, and he's talking about groups can't manage. Well, they can't if they're set up economically not to.

CHAIRMAN ENTHOVEN: We're going to vote on that issue.

DR. NORTHWAY: I didn't vote on this because I didn't have -- I guess I'm one of the people in this room who didn't have the paper in front of them, which I find very offensive. I mean, how can some people have in front of them -- know what they're voting on and some of us not and then you expect us to vote? I'm just not going to vote under those circumstances, Al.

CHAIRMAN ENTHOVEN: J.D., I regret that you didn't. When the meeting began, I didn't either. But I recognize that, in the flood of faxes that came in the other day, this was probably there.

DR. RODRIGUEZ-TRIAS: This was distributed --

MS. DECKER: This was distributed at the last meeting.

CHAIRMAN ENTHOVEN: We'll go back to the original paper, Recommendation 2, which I propose that

we have an up or down vote on the whole thing, on A and B, because they really go together. So Recommendation 2 --

MR. LEE: I don't think they do go together. They're very separate issues, if I may.

CHAIRMAN ENTHOVEN: (Reviewing document.)

All right. Sorry. Okay. Fine. So the Recommendation 2A, all in favor -- I read the modifications.

DR. NORTHWAY: Didn't we just vote on that?

CHAIRMAN ENTHOVEN: We were about to and then Nancy said that that didn't reflect what she was trying to say. So -- I guess we take that out of -- Nancy, we take that out of here about negotiation?

MS. FARBER: Yes.

CHAIRMAN ENTHOVEN: So the only changes, then, are the last sentence "to oversee the medical group's clinical administrative financial capacity and ability to bear the financial risks."

All right. Those in favor, please raise their right hands.

(Committee voting.)

CHAIRMAN ENTHOVEN: Those opposed?

(Committee voting.)

We're now quickly going to move on to Recommendation 3 -- sorry, Recommendation B, health plans that choose to retain the pharmacy benefit and

develop the formulary to their members should include input from practicing plan physicians, specialty sites and other relevant data when composing the formulary.

All right. All in favor, raise your right hand.

(Committee voting.)

It has a majority.

MR. HIEPLER: Where was Mr. Shapiro's comment about clinical issues under pharmaceuticals that he brought in terms of physicians in --

MR. SHAPIRO: That was under B, under B which was defeated.

CHAIRMAN ENTHOVEN: Now we go back to the basic paper. Before we -- I'm hoping we'll be able to vote on this fairly quickly. I'm concerned about the wording of the language. As I understood -- and I'll just ask the lawyers to help us here -- as I understood, the intent was to say that, if a patient was injured through negligent action, that the health plan could be held liable to the extent that it contributed to it.

So if the judge or jury said they were 50 percent contributors, then they would be responsible for 50 percent of the damage and that that is different from the wording here. I'm not a lawyer, but I understand, if you have "joint several," it means if one party is judged to have committed 50 percent of the damage and the other party can't pay, then the former

party has to pay it all.

Steve --

MR. ZATKIN: That's the rule of joint several liability as applied in California.

CHAIRMAN ENTHOVEN: So we don't want to have "joint" in that thing if we intend it to be -- if we intend it to be that each party is in proportion to its own share of the damage; right?

DR. SPURLOCK: Alain, when lawyers talk about it, their concern was that -- you can have three different lawsuits for an action. You can get -- all the limits and all the damages could apply three times. I don't know (inaudible).

But I think the intent is that, if there is a negligent outcome, if there is one action and there may be multiple parties (inaudible) that depended upon the extent that they're negligent. I think that was my concept. We don't want to have multiple actions against multiple parties. I think that's the concern about not having "joint" (inaudible).

MR. SHAPIRO: Al, being a lawyer, I agree with the chair. The problem with joint is you may have a situation where the attending physician actually has no role whatsoever. He has recommended treatment which has been denied by the plan. You could have the plan found to be individually liable for denying medically necessary care.

I think you have to be careful using the

word joint. It assumes there might be more than one entity where in some cases there is only one entity. The point I think the Chair was making is the entity that makes the decision to the extent they're responsible should be held liable.

That may be individual, that may be joint. I don't think you can predict in the recommendation. You simply have to decide whether you endorse the concept of liability for the entity that may cause it.

CHAIRMAN ENTHOVEN: All right. May we proceed on the basis that afterwards off-line I'll confer with Michael and some of the others to see if we can get a consensus on Bruce's intent which is -- the intent is there should be one action, and if there are damages, the parties would contribute to the extent of their negligence and responsibility; right? Okay.

Could we make the discussion very brief. My guess is there are a lot of minds pretty much made up.

DR. ROMERO: Al, just an information note, Bert Alpert has distributed some proposed alternate language that he and Bruce developed. The ERG themselves developed this language and asked that it's a friendly amendment to the Recommendation 3 noted in the paper. We just distributed a single sheet to each of you. It says, "Practice of Medicine, substitute language."

CHAIRMAN ENTHOVEN: Does everybody have this? Let's all read it then. Let's shut up and read it for a minute. Excuse me.

(Reviewing document.)

Did everybody have a chance to read it? They must have since I'm probably the slowest reader here.

MS. FARBER: I have a question. The question I have is that it's referring to all entities that practice medicine, and as we well know in the State of California, we're specifically enjoined from doing that in the corporate practice of medicine. Yet I think everybody understands managed care organizations do, in fact, practice medicine by virtue of some of the decisions that they make.

I just want to make sure that in the Recommendation 3, the substitute language, that we don't get tangled up in that and somehow we eliminate the area of medical practice that managed care companies have now engaged in.

DR. ALPERT: I can speak to that if you'd like.

CHAIRMAN ENTHOVEN: Yes. Go ahead.

DR. ALPERT: The language was chosen recognizing, again, that it's continuing, that there's an ongoing debate and that whole issue will have to be sorted out. This was written hopefully on a higher plane such that all entities that practice medicine to

the extent that our society ultimately decides that they do will be included under something -- under a principle that this Task Force recognized as to accountability for making medical decisions which -- when the state was incorporated, we took from English law remedies for negligence in the health care delivery. And we have held to that up until now. There's a debate now. This was -- at this moment in time, this language was chosen to be above that debate.

MS. FARBER: You're talking about the Legislature will construe the language strictly with respect to corporate practice of medicine.

MS. FINBERG: I think we should substitute health plans, medical groups, hospitals, et cetera, for all entities practicing medicine. We do have it limited later by "caused by medical decisions"; so it's clearly just those decisions that are considered medical. And I think that it's -- we don't want to wait for society to make the determination about entities practicing medicine. It may take too long.

DR. ALPERT: I don't have a problem with that.

Bruce?

CHAIRMAN ENTHOVEN: Would that be considered a friendly amendment?

DR. ALPERT: For me. But Bruce?

DR. SPURLOCK: Fine.

CHAIRMAN ENTHOVEN: Instead of all entities practicing medicine, that would make it look more like the original. So now it would read -- may I just -- I didn't find in this one the thought we had agreed to earlier about parties contributing to the extent of their responsibilities so --

DR. SPURLOCK: It should be in there.

MS. FINBERG: It says "harm made by that entity." I think it does.

CHAIRMAN ENTHOVEN: Let me see. Let me try this. The Task Force recommends to the Governor and Legislature that legislation be passed enabling health plans, medical groups, IPAs, hospitals to be held liable for damages for harm to a person caused by medical decisions made by that entity.

MR. ZATKIN: It's not -- it doesn't limit it I think because it could be a 1 percent contributor, but it doesn't say that your liability is 1 percent.

CHAIRMAN ENTHOVEN: That's why I wanted to add in proportion to their contribution to the --

MS. FINBERG: To the extent.

CHAIRMAN ENTHOVEN: To the extent of their -- okay. To the extent of. Okay. Jeanne, you're a lawyer. I'll take your word for it. That conveys the intent, but it doesn't secretly mean joint several. Okay.

MR. LEE: She's not serving as counsel to you right now, Alain.

(Laughter.)

CHAIRMAN ENTHOVEN: So that sentence would end with "to the extent of their contribution to the damage." And on the rest of the sentence for the people who don't have it is, "In addition, the Task Force recommends to the U.S. Congress and President that the ERISA statutes be revised insofar as necessary to do the same. This liability should be subject to appropriate microlimits to avoid creating incentives for costly lawsuits."

What I'd like to do is just ask --

MR. ZATKIN: What's the lead-in, Alain, about the health plan -- could you read that part.

CHAIRMAN ENTHOVEN: All entities that practice medicine should be accountable for the care --

MR. ZATKIN: When you read the subject of the recommendation, I wondered if that was in there or not.

CHAIRMAN ENTHOVEN: You mean from the preceding language in the paper?

MR. ZATKIN: No.

MR. PEREZ: The language that Jeanne suggested, hospitals --

CHAIRMAN ENTHOVEN: Health plans, medical groups, IPAs, hospitals. Okay? That's in.

MR. ZATKIN: Would you read how it's in.

CHAIRMAN ENTHOVEN: By the way, in view of Jeanne's amendment, do we need the first sentence

"all entities that practice medicine"?

MR. PEREZ: That was substituting for "all entities."

DR. ALPERT: Weren't you substituting for "all entities" in the second one?

CHAIRMAN ENTHOVEN: In the second paragraph.

MS. FINBERG: I think you have to do it twice.

MR. ZAREMBERG: Does this apply to TPAs since you were amending ERISA? Was it intended to?

CHAIRMAN ENTHOVEN: Let's put TPAs in there.

MS. SKUBIK: How about PSOs?

CHAIRMAN ENTHOVEN: PSOs.

Here is then now Recommendation 3: "Health plans, medical groups, IPAs, hospitals, TPAs, PSOs should be accountable for the care they provide and the impact of their medical decisions."

"The Task Force recommends to the Governor and Legislature that legislation be passed enabling health plans, medical groups, IPAs, hospitals, TPAs, PSOs to be held liable for damages for harm to a person caused by medical decisions made by that entity to the extent of their contribution to the damage."

MR. ZATKIN: You've just -- I thought it was those entities to the extent that they practice medicine.

CHAIRMAN ENTHOVEN: That's what I said.

MR. ZATKIN: No. You just said those entities would be held liable for damages.

CHAIRMAN ENTHOVEN: What do you want?

MR. LEE: It says --

MR. ZATKIN: He didn't want to answer the question whether or not they practiced.

DR. NORTHWAY: To the extent they do.

MR. LEE: We can't hear you with that mic.

DR. ALPERT: I agree. Steve is making a clarifying point that I'm personally in concert with. I don't want to make the decision myself on one basis, whether this was medical or not. That's all being done by society. I want to come in after that, if indeed it was a medical decision, then this should apply and you're simply clarifying that.

MR. ZATKIN: Listing the entities that practice medicine.

CHAIRMAN ENTHOVEN: You want to say all entities that practice medicine, parentheses, health plans, et cetera?

MR. ZATKIN: List the entities that practice medicine.

MR. LEE: I thought the reason to pull the practice of medicine was -- that is subject to so much debate in terms of the term of art in California that by pulling out and leaving in "for damages for

harm to a person caused by medical decisions made by that entity," it still anchors it a medical decision made by the entity, but it's not using the term of art "the practice of medicine." That was the rationale, I think, for pulling it at the first but leaving the concept in the second.

MR. ZATKIN: I was following the letter of the recommendation.

DR. ALPERT: He didn't take anything out. He just added. Steve, could you say exactly how you would have it exactly worded.

MR. ZATKIN: I thought the intent of the change was to say, "The Task Force recommends to the Governor and the Legislature that legislation be passed enabling," then you would list the categories of entities and that practice medicine to be held liable. That's what I thought the intent was.

MR. SHAPIRO: Mr. Chairman, just for the lawyers in the room, the legal significance of that is the practice of medicine is defined in statute and currently does not cover decisions by medical groups and health plans.

So unless you're also recommending that the definition of the practice of medicine be altered, which is a pending bill, then by using that term, the very entities that you site currently do not come under the definition of entities that practice medicine because they don't do hands-on medicine.

So there is a subtle legal factor. If you use that term without changing the definition, you in essence create a loophole that --

MR. ZATKIN: Bernard's language was intended to reflect entities practicing medicine does not change to kind of make a priori decision that these entities practice medicine.

CHAIRMAN ENTHOVEN: That's why we say to the extent that they can be shown to practice medicine.

MS. GRIFFITHS: Mr. Chairman, the original language circulated to the alternates did not have the limitation of having to practice medicine. Clearly by inserting the practice of medicine qualification, it will have the effect of not allowing liability for health plans, et cetera.

It's a very meaningful distinction. Before we arrived here today, I believed we were expecting to vote on a proposal that would not limit it to cases where there was a limitation where it must constitute the practice of medicine.

CHAIRMAN ENTHOVEN: I want to find a way to -- we're getting into wordsmithing. I think we have a fairly clear idea of intent here.

MS. GRIFFITHS: It turns on whether we intend to be able to hold health plans liable or not. If we insert the requirement that it be a practice of medicine, then this language will not -- will preclude health plans from being held liable.

DR. NORTHWAY: Mr. Chairman, what about Mr. Lee's idea about using medical decisions?

CHAIRMAN ENTHOVEN: I put in "harm caused by medical decisions by that entity." Do we still want to have to the extent that they could be shown to practice medicine?

MR. PEREZ: No.

CHAIRMAN ENTHOVEN: All right. Take that out.

DR. RODRIGUEZ-TRIAS: Mr. Chairman, may I ask a question? Are we purposely excluding financial decisions that have bearing on medical decisions?

CHAIRMAN ENTHOVEN: We're saying harm caused by medical decisions by that entity.

DR. RODRIGUEZ-TRIAS: Right. But it may be preempted. I mean, a medical decision may be preempted by the preceding financial decision.

DR. DUFFY: Mr. Chairman -- this is Dr. Duffy.

I will tell you what Al Amado said six months ago when he introduced the ERISA preemption, to eliminate the ERISA preemption, and he said his patients' access to Responsible Care Act closes loopholes and current law that allow the vast majority of health insurance plans to escape legal responsibility for decisions causing delisting the reproductive patient.

Currently self-insured managed care plans

cannot be held liable for a patient's wrongful death for personal injury resulting from plan policies even when these policies directly contributed to patients to doubt their injuries. This is wrong and this bill would guarantee that HMO policies that hurt patients, the HMO be accountable for their actions. This is the senior republican center of New York.

CHAIRMAN ENTHOVEN: What I would like to do is call for a vote on the concept, and you'll all have another shot at it afterwards, the wordsmithing. But I believe that we've got -- we usually can't say it. We're talking about health plans that make negligent decisions that cause harm could be held responsible in proportion to the extent of their responsibilities.

We'll just work on this. We'll get back and recycle with several people of the Task Force that are particularly concerned. So now I think -- I hope -- we can debate this endlessly, but we need to move on.

So I'd like everybody in favor of the concept that they can be held liable for -- if they're shown to be negligent and harm patients, to the extent of their -- the damage they caused. All in favor, please raise their right hand.

MS. DECKER: Does it include the ERISA?

CHAIRMAN ENTHOVEN: Yes.

DR. ROMERO: Make it separate.

CHAIRMAN ENTHOVEN: Barbara, you want to vote separately on whether ERISA should be changed?

MS. DECKER: I just wanted to be sure if that last sentence -- the second to the last sentence is still part of the group.

CHAIRMAN ENTHOVEN: Yes. In addition, the Task Force recommends that the ERISA statutes be revised insofar as necessary to do the same.

MR. ZATKIN: Don't change that.

CHAIRMAN ENTHOVEN: All in favor, please raise your right hand.

(Committee voting.)

We have a majority for that. Thank you for agreeing to vote promptly. Thank you members of the -- we're going to ask very quickly for members of the general public --

MR. LEE: Alain, we didn't get to D which is the last recommendation of the section.

DR. SPURLOCK: I'd like to make a quick comment about this paper. You all received in your DELFI questionnaire the article that was in the "Journal of American Medical Association" that Dave Eddy (phonetic) wrote about a conference held in 1996 to sort of tighten up the language of -- benefit language to make it more evidence based, to have some mechanisms for having (inaudible).

That conference took several days to come to its decision, and I believe the Task Force and DELFI

said this is an idea that's worth more discussion and of interest. But, in fact, they wanted a much more detailed level of debate about this. The suggestion was to develop a panel to accomplish that.

DR. WERDEGAR: Is that in the form a recommendation, then?

DR. SPURLOCK: Yes. Page 9.

CHAIRMAN ENTHOVEN: Page 9 of the paper.

DR. ROMERO: Recommendation 4.

DR. SPURLOCK: Page 7, the second paragraph should say -- Recommendation 4 -- "A blue ribbon house should study the issues of care changing definite language, vague and precise terms to a language to maximize quality health outcomes."

We actually initially had in one of our documents referral to that specific piece. We assumed that that group would do that, but we didn't want to limit it to that piece and put that piece as a vantage to other thoughts. And people might have (inaudible).

DR. ROMERO: Bruce, just a clarifying question. You just referred to the second paragraph under D on page 7 suggesting that should be a recommendation. You also have similar language on page 9, Recommendation 4. Are you --

DR. SPURLOCK: Yes. It's the same. I apologize.

CHAIRMAN ENTHOVEN: Could I just say, this is a very arcane but a very important issue; that

is, the language that health insurance contracts rest on is really pretty meaningless when you have wide variations in medical practice and opinions and so forth.

All health insurance contracts one way or another have language about they only pay for medically necessary procedures but there is no agreement on what is medically necessary because of the wide variations.

So it's just a call to say could some serious people really work on this. Dr. David Eddy, who is a leading thinker on this, has done a lot of work. He's written articles about -- it's really kind of saying just a statement that we need some serious people to take a serious look at this to see if they can come up with something better.

Yes, Nancy?

MS. FARBER: Could I offer a friendly amendment? Based on our actions Friday and Saturday, we had our straw vote and it looked as though the group was pretty much in favor of the creation of a yet to be named agency that would be responsible for overseeing managed care.

But in the event that that is an action of this body, that we would also include them or their representatives in the list of people that would be working on this.

CHAIRMAN ENTHOVEN: That the regulatory agency do this?

MS. FARBER: Yes. You have to be named.

CHAIRMAN ENTHOVEN: Okay.

DR. NORTHWAY: Alain, not that they do it but that they be a member.

CHAIRMAN ENTHOVEN: Oh. Be a member of. Yes.

DR. ROMERO: Chairman, I'd like to -- this is very much related to Nancy's suggestion. In discussion on either Friday or Saturday of another blue ribbon panel, as I recall, we struck the enumeration of specific groups and replaced it with more general language like relevant health professional organizations or words to that effect specifically so that, as I recall, so that nobody felt left out.

If that's other people's recommendation, would it be a friendly amendment to do that again here? Strike the enumeration of specific groups and -- with more general language? That question is addressed to Bruce first. Is that a friendly amendment? Okay. You're indifferent? Okay. It's a friendly amendment.

CHAIRMAN ENTHOVEN: Yes?

MR. LEE: Two other suggestions. I think that's an amendment as it relates to providers but not related to the others. We've had a number of times when consumers or patients had been excluded. When we talk about providers, they're backed different.

DR. ROMERO: Another good point.

MR. LEE: Two things. One is I would

like to have the recommendation read that actually recommend the standard definition not just study the issues. I think that we want a product out of this which is not just an ongoing study.

Second --

CHAIRMAN ENTHOVEN: Exactly where are you, Peter?

MR. LEE: Right where it says "after a blue ribbon panel should." Instead of study the issue --

CHAIRMAN ENTHOVEN: Study and recommend?

MR. LEE: Which version are you using?

DR. SPURLOCK: Page 9.

CHAIRMAN ENTHOVEN: Okay. Study and recommend. Friendly.

Bruce?

DR. SPURLOCK: That's fine.

CHAIRMAN ENTHOVEN: Any other discussion?

MS. FINBERG: Do we add "consumer" there? We do. Okay. Thank you.

CHAIRMAN ENTHOVEN: After "providers" we'll put "consumers and other appropriate health care professionals."

MS. SEVERONI: Chairman, I want that line to pick up the way you said it. I think it would be really helpful if we identify what we mean by "stakeholders" not just for this paper but for all the papers at some point in the beginning of the report to

say that on every single recommendation we made, when we use the word "stakeholders," we are considering consumers within that group.

CHAIRMAN ENTHOVEN: Okay. That's a friendly amendment. I really would like to bring this to an end as soon as possible.

MR. GRANT: Just briefly, Mr. Chairman, we provided the members today with a paper which adds three separate additions to this recommendation. Page 4 of the Health Access paper, practicing medicine.

The first one would be that the panel acknowledge that decisions of coverage really do equal decisions of care. And that in their deliberations, as the language suggests, that the decisions you cover really does (inaudible) to provide care and health plans.

The second recommendation would be that benefit definitions should take into account particular needs of particular populations, specifically the elderly and disabled, and reflected care would be focused on maximizing functional capacity so that things like physical therapy and skilled nursing facilities and so on are considered.

And then the third recommendation we feel is important because it would address the issue that we feel currently there's an incentive in the cost reduction. The cost reduction may, in fact, outweigh the quality of care. As the language suggests,

(inaudible) of benefit criteria should take into account the impact of reducing or eliminating coverage as part of their charge.

So we feel this is not simply (inaudible) as Dr. -- we feel Dr. Eddy's article could be led to believe. It simply focuses on reducing costs.

CHAIRMAN ENTHOVEN: Let's take a moment. You've italicized the things you want to add?

MR. GRANT: That's correct.

MR. LEE: Could I suggest, rather than voting on whether we agree with each of these, say "among the issues the blue ribbon panel should consider are the following" and include the italicized language. So you don't have to vote whether you agree on any one of these, but it's giving direction on the issues that need to be covered and note that it's not an inclusive list of the issues.

CHAIRMAN ENTHOVEN: Okay. Thank you. That's helpful. I really don't want to debate these issues. Thank you.

MR. WILLIAMS: Given the broadening nature at the end of the first paragraph where we say, "the state should require the implementation of these changes," could it be phased in something like "if feasible the state should require"?

CHAIRMAN ENTHOVEN: Ron, are you back to the original text?

MR. WILLIAMS: Yes. I'm back to the

original text where -- the last sentence of paragraph A, there's a resumption of implementation.

CHAIRMAN ENTHOVEN: Where feasible?

MR. WILLIAMS: Yes.

CHAIRMAN ENTHOVEN: Okay. All right. Let's see. Among the issues that should be --

MR. LEE: -- "that the blue ribbon panel should consider are" and then include the list of the italicized language that is submitted here.

CHAIRMAN ENTHOVEN: Do you consider that a friendly amendment?

MR. GRANT: That's fine.

CHAIRMAN ENTHOVEN: All right. We'll -- I'm going to package that as kind of C you might say; so we'll go down.

All in favor of Recommendation 4A, raise their hands.

(Committee voting.)

Majority.

All in favor of Recommendation B with the amendments that we've discussed, all in favor, please raise your --

MS. DECKER: I got lost. I thought the amendments were all to A; so now I'm confused. What amendments to B?

CHAIRMAN ENTHOVEN: To B, Nancy Farber, convened by the Office of State Health -- an oversight or whatever, the appropriate regulatory agency pro --

after review of panel providers, consumers, other appropriate health care professionals and health plans.

MS. DECKER: So this is talking about experimental treatment and you want the state regulatory agency (inaudible). I'm looking at Nancy for her to say "yes."

CHAIRMAN ENTHOVEN: Was to convene the panel.

MS. FARBER: I don't know that I said it was to convene the panel, but they should be a participant, they should be in the loop, in that process if they're going to be responsible for regulation in the managed care industry.

MS. DECKER: Did you mean to modify A or B?

MR. LEE: On page 9.

MS. FARBER: B.

MS. DECKER: Okay. B. Okay. I thought the benefit language was the thing the state agency should really be involved in; so that's where I thought it was supposed to be. Sorry for the confusion.

CHAIRMAN ENTHOVEN: All in favor of B as amended, please raise your right hand.

(Committee voting.)

We have a majority. Okay.

All in favor of what I'm going to call C, which was Peter Lee's friendly amendment to the Health Access which is to say "among the issues that should be

considered are" and then take the italicized pieces of this. All in favor?

(Committee voting.)

MR. LEE: Alain, I'd suggest that really be part of A. That's who we're suggesting consider that is the blue ribbon panel.

CHAIRMAN ENTHOVEN: Okay. We will word this so that it's issues to be considered rather than conclusions being reached; right?

DR. GILBERT: Alain, did you get a sense that that was a clear majority? There were a number of people in opposition that you didn't ask.

CHAIRMAN ENTHOVEN: I'm sorry.

MS. SINGH: It was a clear majority.

CHAIRMAN ENTHOVEN: Do you want to revote?

DR. GILBERT: I couldn't tell if it was clearly a majority. We're talking about adding substantial, additional verbiage that recommends --

CHAIRMAN ENTHOVEN: Okay. Let's ask again. All in favor, please --

MR. ZATKIN: Alain, you're adding them not as endorsing what they say but as issues to be addressed?

CHAIRMAN ENTHOVEN: Yes. So there may be some modification like "in reviewing benefit definitions, reviewers should be aware" -- well, we won't say "should be aware." We'll say "should

consider," et cetera.

MR. PEREZ: Why don't we vote again.

CHAIRMAN ENTHOVEN: We'll take a vote. As revised to say it's something that should be considered and reviewed, it's not a conclusion but a question. All in favor, raise your right hand.

(Committee voting.)

This does have a majority. Thank you.

Now, we will have -- we have two people who wish to speak on this. I would appreciate it if you would make your remarks very concise. We have Maureen O'Haren from California Association of Health Plans.

MS. O'HAREN: Good morning. Thank you, Mr. Chairman, members of the Task Force.

I'm Maureen O'Haren with the California Association of Health Plans. I want to make a couple of comments on some of the recommendations. And I apologize for going back to the beginning, but that's where I'm starting.

The recommendations involved in Recommendation 1 are based on Lifeguard's program of gold carding physicians based on their record in complying with certain protocols. And I apologize for using the term gold card if that's not acceptable, but that is the term they used.

I talked to Dr. Ada (phonetic) about this recommendation, and he feels it needs to be made clear

that you can only gold card somebody for those procedures for which there are clear objective guidelines in place. And that is a limited universe of procedures. And whether the person has a catastrophic condition or not really doesn't matter. It's whether or not you have clear objective guidelines.

So I would frankly recommend that C and D be collapsed because it would depend upon whether or not you had clear objective guidelines for procedures that are involved with the catastrophic condition.

You can't just say that all the care for this person with a catastrophic condition can be just -- you know, ignore the prior authorization because there are a lot of complicated things involved with a person with a catastrophic condition.

For example, there may be home help involved, there may be other acute, subacute facilities that you want to get involved and that may be a whole different process. You want to involve the plan in decisions about clinical care settings.

So I think that to imply that the whole continuum of care for a person with a catastrophic condition can do away with prior authorizations is probably misleading. Because as Dr. Alpert said, you want to make sure there are some outcomes, some guidelines in place.

The other issue is the two-year limit, what is probationary period. Lifeguard does collect

data -- they have collected data on the physicians for more than four years now. They are in good place to do this. But they are unusual among plans of this nature.

They, I believe, watch the provider over a period of time, and if they have performed well over a certain period, they will gold card them. But I don't know if you want to limit this to two years and say, "If you don't make it in two years, you don't get to try again."

I think maybe what the plans enacting this kind of thing would want to do is establish a period over which the person has to perform to guideline. If they don't make it in the first year, then maybe the second two years.

So limiting it to two years basically means a person gets two years, and if not, then they never qualify for a gold card. I don't think that's what she intends. So I don't know that that is necessary.

The other thing that I think needs to be made clear is that, even with Lifeguard's gold card program, the physicians still must call the plan in order to check eligibility, in order to verify coverage for that particular benefit, to make sure that the setting -- the particular center chosen is appropriate. So they don't have to submit clinical information. They don't have to go through that. But they still have to call the plan.

The other thing Dr. Alpert asked, what do we think about the year 2002, I would strongly encourage the Task Force not to make very specific recommendations like this.

We don't know -- some plans do not have the resources to implement the data systems, some of the medical groups may not when they're delegated this. I think we need to sit down and figure this out. I think some legislative oversight needs to be done.

But I would be cautious about recommending any particular dates since we don't know. Frankly, I think that, rather than focus on doing away with prior authorization, we ought to focus on improving the process, setting time frames for approval so we don't see the 30 days and 60 days. And I think the dispute resolution paper talks to some of the back end stuff.

A couple of other comments on some of the issues. I think the formulary discussion --

CHAIRMAN ENTHOVEN: Maureen, you have exceeded your three minutes. I have to ask you to --

MR. SCHLAEGEL: Could I ask her a question?

CHAIRMAN ENTHOVEN: Yes.

MR. SCHLAEGEL: Does Lifeguard feel that this procedure that they developed is successful? And is it eliminating cumbersome calls to their health plan?

MS. O'HAREN: Yes, I think they do and that's why they institute it, to reward those doctors and let them go on practicing, yes.

DR. ALPERT: I'd like to --

CHAIRMAN ENTHOVEN: You need to --

DR. ALPERT: I'd like to correct something that was stated.

The, quote, unquote, "gold card" verbiage that we use in the recommendation is not, and I quote, based on Lifeguard's system, et al. It was what we came up with.

Number 2, Lifeguard -- I was very impressed with it. I'm sure they'll do very well, with the constraints that are outlined in our proposal, to take good companies into account.

CHAIRMAN ENTHOVEN: We have one more speaker. Beth Capell, Health Access. Beth, I hope you'll note the ideas on the last point were adopted as modified so --

MS. CAPELL: We do, and we appreciate your consideration of that, Mr. Chair and Members. We were, when we initially saw Dr. Eddy's article, very alarmed of the potential implications to consumers. So we are appreciative of that.

Just as Maureen did, I need to go back to the beginning of your discussion. Two points, one of which I believe is in the spirit of the discussion and one of which is very important to consumers.

We believe that whatever practice guidelines or clinical pathways are used ought to be developed by practicing health professionals, including not only physicians but nurses and others. Much of the controversy that has arisen around these issues actually has to do with cutting off nursing care rather than physician care. Sending a patient home early from the hospital will cut short the nursing care they would receive rather than physician care. So we encourage you to reflect that.

The second point is these guidelines should be available not only to the patient and the treating health professional but also for review by consumer groups and health professionals, specialty associations. We think that thoughtful consideration of these -- we think of discussions we've had with the Alzheimer's Association, for example, about feeding patterns for Alzheimer's patients -- would improve the quality of this as we go through this process of trying to improve the quality of care. Thank you.

CHAIRMAN ENTHOVEN: Thank you.

We will now take a five-minute break. I would appreciate it if people would hold it to that, and then we will come back and spend two hours on dispute resolution so everyone will have an incentive to finish that before we eat lunch.

(Break.)

CHAIRMAN ENTHOVEN: We will now begin

dispute resolution. We're scheduled to spend two hours on this. This has the important advantage that, by the time we finish at 1:21, the crowds will be out of the restaurants and we'll be able to get our lunches without waiting in a queue.

This is going to be a very challenging session because there is a lot of material to cover here. So we are asking you to acquiesce and sometimes being run roughshod over as we charge through this.

I hope we can use the device that, if we believe we have consensus on a concept, we'll move forward without fine tuning all the wording and we'll get back to particularly interested people on some of the wording afterwards.

Arguably, I think all of the papers we've been working on are very important and I think in many cases they sort of fit together and are mutually supportive. From the point of view of dealing with the managed care backlash, this is one of the few most important places where we may be able to do something that would cause people to feel that they are being done prompt justice rather than bureaucratic rigmarole and so forth.

This is a really important thing. I'm very grateful to Peter Lee and Barbara Decker for having done a great deal of work on this; so I'll turn it over to them.

MS. DECKER: Good morning. First of all,

I just want to mention that Peter and I have been trying to figure out how to make this happen, and we're all going to be challenged to do this within the time constraints we have. So I echo Alain's comment about roughshod. Don't take this personally. We just need to keep it moving.

We figured out we have to vote on 21 items; so we're going to try to move this very quickly and limit discussion on any item to no more than five minutes. We might go over a little bit, but we'll try to keep the momentum.

A brief comment about how we developed this document. We did try and go through a process of gathering information. You might remember the DELFI questionnaire that was sent out that we appreciated the responses, and we have used that information to guide many of the suggestions that are in here.

We also did a survey of a number of different groups, including health plans, asking for information about how the processes work currently. We got lots of comments and used all this information to come together and develop this document with much hard work by Sara Singer in getting it together. So we really appreciate all the staff time that was involved on this particular document.

I'd like to just highlight on page 1 the "Essential Elements" section. We're not going to hopefully vote on this. I just want to set this in

your mind as part of the stage that we've been working from. I'm going to just walk through these very high-level.

First of all, consumers need to understand their rights and responsibilities. And the key to me is they have to know how to navigate a dispute resolution process just like the rest of the health care system.

They need to have quick resolution, and this needs to be as close as possible to the point of service; so if decisions -- if problems can be resolved in the provider's office, we'd rather see it happen there than be elevated at all.

But we have to recognize that in our health care system in California, some consumers will need assistance. There is always somebody that can't quite figure out how to make it work. So we need to be ready to provide them some way of making the system work for them.

We need to be sure that the processes are fair, that people are treated alike in like situations, and perception is important and that they must be perceived as fair. They have to have consistent decisions, have information communicated effectively to the parties involved, make sure the decisions are made by people that are qualified to make the decisions.

But at the same time, we have to balance efficiency. We have to be sure that we are making

decisions in realtime. When there is a severe situation, the decision needs to happen promptly. There must be a way to have a person recognize this is it, this is the final part of my dispute and feel like they've reached a proper end even if it's not a favorable decision.

And then, finally, one of the key items for me personally has been the whole dispute resolution process to me provides great information for improving the system. And we need to be sure that the process is being used in that way, that the information you gain from understanding where the glitches are can help you make it much more effective going forward. I would now like to move to page 2.

Starting in the recommendations --

MR. LEE: How we're proposing to do this as a matter of process is we are going to run through everything. We're going to go through each recommendation one by one and at that point do our five minutes or less.

And we've been sort of gold carded to try to -- back and forth facilitation; so we'll be keeping a speakers list here. But if we can go less than five minutes on easy ones, don't comment on them, please, so we can have more time for some of the ones we do need more time on.

Also, if you've got technical suggestions that -- for instance, Knox-Keene really says this or a

little different, get those to us, and we'll incorporate those later. Let's focus on the major substantive issues. Both Barbara and I will try to flag for you, say that we've had comments that say this is too much or this is too little; so we'll try to identify those as we go through.

MS. DECKER: So we're on page 2 under the recommendations, Item A, and the first recommendation numbered 1, I think this one should be noncontroversial. It just indicates that we want to build on what's already available, that we need collaborative processes that involve health plans, purchasers, providers, consumer advocates, and other stakeholders so that we want the real detailed work to be done in a spirit of the key people that have opinions and views are involved.

And that specifically there's already a standard that's in place someplace else. A typical example is Medicare might have a process in place that we should look to see can we use that instead of creating duplicative or repetitious or slightly different variations.

I'd like to open this for any comments. And I think this is hopefully a brief one. Does anyone have any concerns or comments about the idea that we treat all the future recommendations on a collaborative basis to be spelled out and made in more detail?

MR. LEE: Move on.

MS. DECKER: Item 1 is majority.

Item 2 --

CHAIRMAN ENTHOVEN: We can just say "without objection."

MS. DECKER: Without objection, we move on to No. 2.

Number 2 is talking about broad application. We have concern and we will address this more clearly towards the end, probably when we're all totally ready for lunch on page 6. We'll get into ERISA.

But here we made the recommendation that in those situations where there is an ERISA preemption, we suggest strongly and recommend to employers that they go ahead and voluntarily adopt these recommendations because obviously an employer in an ERISA type arrangement could choose to go forward with these even if they're not legally required. So this is a voluntarily compliance recommended on the part of ERISA plans.

Any discussion on this item?

MR. CHRISTIE: As far ERISA plans are concerned, as I understand it, the issue that would come down would be a case of having some recourse, some lawsuit or liability recourse against the plan. My understanding -- there needs to be some facts that the Chairman could bring to the discussion -- is that most enrollees are in plans that are ERISA based.

So unless you're talking about lawsuits of that area, you're primarily talking about medical issues when it comes to coverage and grievance process. So ERISA would have to deal with lawsuit issues. Is that what you're interested in bringing up?

MS. DECKER: Actually, I would take it a little broader. ERISA has its own requirements on process, about how quickly you have to respond to a dispute, what kind of information has to be shared with the claimant. It outlines a certain requirement on the part of an employer who initiates a plan.

Now, frequently in California, particularly this is delegated to a plan so it looks the same. But in actuality, legally an ERISA employer could chose as long as they comply with those requirements to say you have 60 days before we will answer your first complaint about a situation.

So it's not just the lawsuit aspects. It is procedural matters. And what we're saying here is if in the subsequent discussion about ERISA, which I'm trying to hold off on until later, whatever happens there, we still think employers who have ERISA plans should voluntarily look at these recommendations and adopt any and all. We think it's worth their going ahead and moving ahead and having consistent hand withdrawal of their employees in California.

CHAIRMAN ENTHOVEN: Very roughly 40 percent or so are not under ERISA because they're

public sector or individual purchasers of coverage. So it's ERISA. And these numbers are rough. It's roughly 60 percent plus or minus.

MS. DECKER: Hearing no objection, we will adopt No. 2. Now we'll move into section C, and Peter will facilitate.

MR. LEE: When we say "adopt," we carry that language across to the next meeting to be voted on is what we mean.

I'm going to run through Section C, A through H. Again, I will try to flag issues that have been brought to our attention of concern or controversy and solicit comment. And then where we need to, do straw polls, otherwise do without objections.

The first is to move something that is out of order which is G. If you look over at G instead of A, there's the point that -- the point of this whole section is that we want to have standards that are consistent and cut across both plans, medical groups, regardless where possible a payer or where the person is getting their services.

And I'd like to -- the intent of G, which would be the new A, I'd like to reword which is the intent is that where care is provided at the medical group level, a consumer that has a grievance or appeal, that all of the timely requirements and standards run directly to that medical group.

We are not saying that basically timing

starts once at the medical group and again at the plan level. The intent here -- and it does need a little wordsmith here -- some unclarity was brought to me as saying are we suggesting we have a separate whole process, whether it's 30 days or whatever, for medical groups and for health plans?

The intent is absolutely not that. We're saying where a medical group is working on behalf of the health plan. All the standards, when we talk about health plan, run directly to that medical group. So that's the intent of G, new A.

CHAIRMAN ENTHOVEN: Friendly amendment, "medical group," slash, "IPA"?

MR. LEE: Absolutely. "Medical group or IPA."

Any comments on that concept which needs to be better wordsmithed to come back for the vote?

Without objection, moving to A. I'm not going to renumber these as I go. I'll call them as they're on the paper. The -- one of the first issues we noted a desire and a need for consistency is with regard to timing. This A addresses timing in three ways.

The first is standard timing relative to regular complaints which we note should be within 30 days except under special circumstances. Second is basically expedited timing for when it is urgent and life threatening. And third is timing of periods of

limitation.

And what this means is if someone has appealed something or raised an issue, when do they have to reappeal it or lose their rights? Those are the three separate things addressed under A. One of the observations made, which is a very good one, is that we do not identify in -- timely requirements.

Currently one of the timely requirements under Knox-Keene is you have to have basically been working with your plan for 60 days before you get access to Knox-Keene as a place to file a complaint. To my mind, that's a bit of a technical amendment that we could put in to clarify what's on the books.

I suggest we move through these as the three separate points to see whether there are comments, concerns. So, first, relative to the 30 days, are there any comments, concerns, relative to the 30 days?

MR. KNOWLES: What page are you on?

MS. DECKER: Page 3, Item A, and we're on 1.

MS. BERTE: The Department of Consumer Affairs manages the state's dispute resolution process. It also has a program called Arbitration Review Program that certifies that lemon law arbitration programs of manufacturers (inaudible) --

CHAIRMAN ENTHOVEN: Marjorie, speak more clearly into the mic.

MS. BERTE: -- they have limited expertise in this arena. I would question the use of the word "handling." For us handling probably implies -- we handle 35,000 complaints (inaudible). Handling to us would mean closure. I don't know that you can mandate closure depending on what develops in the process of responding to an investigation of a particular plan. You have to be careful how you word that.

MR. LEE: I should cover that the intent is closure. That is the intent. I think it's a very good point to identify; that is, outside of special circumstances, plans or wherever this is happening should reach closer. It may not be the answer a consumer likes, but the 30 days -- that's actually the intent. I think that's a good clarifying note.

MS. BERTE: I guess I would question it again. 35,000 complaints a year we do through our litigation division where we have licensure threat (inaudible) the two parties to the complaint, and our average turnaround time, which we've been attempting to reduce significant closure time for, generally satisfactory results for both parties is -- has come down from about 63 days 3 years ago to about 43, 44 days now. And that is with initial response to receive the complaint within 72 hours. So I just want to give you that data.

MS. DECKER: One thing that might help in

understanding this is that it would not be coming to a central agency. This is handling a complaint wherever it's initially made. So it's very dispersed throughout the health care system with a lot of different entities being able to respond to individual complaints.

CHAIRMAN ENTHOVEN: Let's just talk a little bit about what's so important about 30 days. Considering that in many cases these are medical disputes that have to be researched, I think one of my students who became a medical director for the Palo Alto clinic -- or managed care director, she said, "We had an irate patient who heard somebody in Canada invented a new therapy," and she just said, "Could you give us a little time to investigate this?"

And I just think if complex medical issues are involved as they sometimes get to be, we just don't want to lay on something that seems arbitrary and short. I don't know how you wordsmith that. But some things require a search of the medical literature, checking out the person in the remote location who claims to have the solution to the problem and so forth.

MR. LEE: Michael?

MR. SHAPIRO: I think the Task Force would benefit just understanding what existing law is. Because for the most part, this reference is to existing law. That under statutes that were enacted two years ago, because there were no specific

deadlines, we have a couple of situations.

If someone files a grievance, the plan has 30 days simply to respond, not to complete the grievance but to let you know the status. The previous regulation that urged closure within 30 days is feasible. That hasn't changed.

There is in existing law a requirement to deal with emergency situations as a fine, which is actually currently a 5-day rule. This would change it to a 72-hour rule. There is under existing law a requirement that if after 60 days the dispute is unresolved and the enrollee is frustrated, you can stay with a plan as long as you want if they're looking at medical issues and you're not alarmed by it.

But if after 60 days you have an unresolved dispute, the enrollee has the option at that point. Usually what the intending physicians who appeal to the Department of Corporations, most of them stay with the plan if they're in the midst of discussions on medical issues.

But that was there because we had too many instances of plans having 4-tiered reviews that went on for over a year and there was no ability to have closure and take it to the Department of Corporations.

We have heard no complaints with that 60-day rule creating inflexibility in dealing with ongoing medical issues. But that's the state of

existing law that was put on the books two years ago.

MR. LEE: Tony.

MR. RODGERS: Are you differentiating between a complaint and a grievance?

MR. LEE: No.

MR. RODGERS: So any complaint of an individual would appear as part of a grievance resolution process?

MR. LEE: Correct.

MR. RODGERS: There are very minor issues that -- or clarifications that come in as complaints, but what you're required to do is clarify a particular issue with a person?

MR. LEE: Right.

MR. RODGERS: So you want them within this process. I assume you're going to start talking about tracking.

MR. LEE: We are, yes.

CHAIRMAN ENTHOVEN: After "specific circumstances" at the end of that statement, could you say in parentheses "in which medical evidence must be researched"?

MR. LEE: I mean, I think we'd be happy to look at sort of existing law to note some examples of. The point here really is in most cases issues can be resolved in those 30 days. It's where special circumstances exist that used to be a safety valve to make sure the decision was made appropriately.

Alan.

MR. ZAREMBERG: I'm confused. Michael indicated that they adopted the process two years ago, I believe, and this appears to be different than that process.

MR. SHAPIRO: The only variation I see is the 72-hour rule versus the current 5-day rule. There may be others, but I think I'm missing something in terms of found differences. But this process is in place with the exception of the deadline on emergency --

MR. ZAREMBERG: I think it would be helpful for me, Peter, before you answer questions, how does this differ from existing law that was changed two years ago and why is it necessary? What problem does it accomplish? What's the problem in the existing law that was adopted two years ago? That will be helpful.

MR. LEE: One thing that this does which is different is that this time frame we recommend should apply to PPOs as well. As I understand the law specifically related to Knox-Keene plans, it doesn't cut across HMOs and PPOs.

There is the same time frame for PPO plans that handle the problems for this time frame. That's the primary difference, I think, with existing law. And the 72 hours versus 5 days is the other.

MS. DECKER: But you'll note as in the document that the 72 hours applies to existing

requirements under Medicare.

MR. LEE: The primary difference is extended across health plans including those --

MR. ZATKIN: Could we have a clarification on the last point about whether the 72 hours -- I know there is a 72 hour rule in Medicare. Is it applying in the same way that this is proposed? I had some information that maybe wasn't -- could I ask Maureen O'Haren?

MR. LEE: Before we do this, if I could reach closure on the 30 days. We'll take one last comment on this.

MR. ZAREMBERG: Could somebody explain how PPOs resolve these things under existing law? I have no idea. I'd like to know what this is about. Because you're expanding into PPOs, how do they do it currently under existing law. Was it considered two years ago when the changed the law for HMOs? Was it rejected? Was there a reason for that? I just don't feel like I have information on this.

DR. DUFFY: From a practice standpoint as a spinal orthopedist, I'll tell you exactly how it has worked. It is a classic case. This man is an executive, he gets a bad disk, he's in mortal anguish, but he's not paralyzed and has not lost bladder functions. He's rested, in therapy, on medication. He's lost on his job.

He's four weeks along, the request is

made to operate on the disk with a positive MRI scan. It is refused because the protocol says he must go six weeks. They appeal it. By the time they appeal it and he does get operated on, he goes back to work in two months, loses one month of work and he's president of the chamber of commerce we'll say.

MR. ZAREMBERG: That was my question. My question was what is the difference between HMO -- why were they left out of the --

MR. SHAPIRO: Al, just to plead responsibility, the focus in the Legislature was with health plans. And, in fact, had I known there was a 72-hour rule in place in other plans, we would have pushed for that rule. We were told 5 days was the norm.

We weren't looking at PPO situations. Subsequently Peter was looking across all health care, discovered that we had these dissimilarities on that. So I plead the fact that we were focused on health plans, the complaints were about health plans, and we weren't aware of some of these other problems because they weren't brought to our attention.

DR. DUFFY: In my office, the PPO, I was able to speed it up on a direct appeal. I faxed information, they approved it, and got a man taken care of under similar circumstances. So I was able to move faster on the appeal basis.

MR. LEE: We'll go to Brad, then Ron, and

then on the 30 days we're going to do a quick straw poll.

DR. GILBERT: Michael, correct me if I'm wrong, but the requirement now is after 60 days the individual could go to DOC but there's no requirement that there's a solution in a particular period of time. It's the urging that it be done in a certain period of time.

MR. SHAPIRO: Right. Basically it stimulates plans to not do what they used to do which was have extended tiered review because they know that there is a risk enrolling -- moving the grievance to a a regulatory agency. In most cases, we think the plans are getting it done. And we always refer you to the plan first.

DR. GILBERT: In addition, there's a requirement to report any grievances that go over 30 days on a quarterly basis. My concern is that we're saying medical groups are part of this entire time frame. If a plan has a 30-day period, you're basically giving the medical groups two weeks at the most in terms of their ability.

And I agree in many circumstances it's appropriate for the medical group to be trying to resolve the grievance because they're the ones that made the original decision, I mean, of closure to the direct delivery of care.

But if you shorten it to 30 days, you're

basically giving them about two weeks maximum. The plan will have to immediately defer to them because they'll have to try to meet that 30-day window period if the group can't resolve it. So I'm concerned about 60 days referring to DOC down to 30 days for the entire process.

MR. SHAPIRO: Let me make very clear what Peter did not. The 30-day rule currently applies to medical groups. That's existing law. The medical group is essentially an element of a health plan. If someone has a grievance and they finally decide they want to write it down in the form of a complaint and then submit it to any entity associated with that health plan, the physician medical group plan, the 30-day clock starts under existing law. Medical groups are health plans if you're going to delegate that responsibility. So what Peter has done is he has restated existing law.

DR. GILBERT: I have no problem with the delegation of holding the system accountable with the time frame. My only concern is 30 days seems a little -- we've gone from 60 days voluntary turnover to DOC to 30 days total including --

MR. SHAPIRO: 30 days is just a status requirement. After 30 days somebody in the plan or the physician has to tell the enrollee about the plan, here is the status of your complaint. It doesn't have to be resolved in 30 days.

DR. GILBERT: I understand that. My point is this is saying resolved in -- doesn't it say -- Peter, could you clarify, this says turnaround time for handling complaints. Is that responding or is that proposing a resolution?

MR. LEE: I think -- my intent was resolution, again, without special circumstances which could go to 60 days. This does not propose changing when you get access to the DOC under the 60-day access plan.

DR. GILBERT: So it's not a 30-day response. It's a 30-day proposed resolution. So, Michael, there is a big difference.

MR. SHAPIRO: Well, I was just corrected by Maureen O'Haren, who has read the statute recently. It apparently is your attempt to resolve it, but the clear language -- legislative intent says if you have it, you're not in violation of law, you then have additional time. So I think it might -- you're basically restating existing law; so you want to apply to a broader group.

MR. LEE: Take it to restate existing law.

MR. HAUCK: Why do we want to do that?

MR. LEE: To cut across, again, HMOs and PPOs.

MR. WILLIAMS: To go back to the issue, I'd like to comment on. I come back one more time that

at the end of the day we are determined to make PPOs look like, act like, and function like HMOs. The basic promise that most PPOs make are -- is a promise to pay.

They agree to indemnify you and they agree to reimburse you at greater or lessor levels depending upon your use of in network or out of network providers. They do not have to take a responsibility under the insurance code as I understand it to arrange for the delivery for health care services.

So I think the reason they weren't part of the original legislation where I sit was an appropriate decision that said consumers do need a fair and appropriate methodology and process to be certain that they are getting values for the premiums that are paid.

But at the end of the day, we will end up with only HMOs in California, only DOC licensed M.D.'s and consumers will have substantively less choice than they have today. And we're trying to solve very real issues. But I think a prime as to PPO will result in undertaking the consequences.

MS. DECKER: I just wanted to respond a little bit to Ron because I agree that PPOs do make a different kind of commitment, but they will get a different kind of complaint. So the kinds of complaints that you have to respond to are not about the referrals, et cetera.

The person is navigating the system

themselves; so I still feel like there is a basis to say let's try and make it a real commitment among the health care industry to respond to complaints within 30 days.

I think it is in our society where everybody is getting faxes and getting pages within 15 minutes of when anything happens, I think the cycle time has to be more realistic towards the days. People in a health care situation aren't used to having to wait three weeks for an answer to their request.

MR. LEE: Clark.

Then we need to stop to do the other parts of the paper.

Go ahead, Clark.

VICE CHAIRMAN KERR: I think from a consumer standpoint, the consumers don't really think of they're joining an HMO or a PPO. They think of different plans and so on. I think it -- whether they buy a minivan or a corvette, if they have a lemon, they expect to be able to appeal it similarly.

That doesn't mean that the minivan and the corvette aren't different types of vehicles. So I don't really see this as the same. I think it's just you have to see recourse from a consumer standpoint. That just makes sense.

MR. LEE: I need to do a straw poll on this. The main issue again to the first is what is conforming with existing law so it's not expanding it;

and, No. 2, it's cutting across delivery systems.

So can we get a straw poll on -- for that part of timing. Those in favor, please raise your right or left hand.

(Committee voting.)

Moving down to the next part which is 72 hours versus 5 days. As Michael noted, existing law is a 5-day turnaround requirement. One of the things we tried to do is have consistency that does cut across payers as well.

Medicare -- and it has been recently adopted a 72-hour turnaround time for expedited, urgent appeals. There have been concerns raised that this is not well tested by HCFA because it's been instituted recently. Our concern, again, was to try to have consistency that comes across payers so when someone converts from one type of payment system to another, they don't have the playing field change on them.

Ron.

MR. WILLIAMS: In terms of the 72-hour rule of HCFA, I think there's a matter of clarification that's helpful for the group to understand is that, as I understand it, 72-hour requirement for HCFA applies to initial determination and reconsiderations for urgent cases that cannot be appropriately handled to the normal utilization review time frame which is 60 days. So what they've done is say that normally we expect 60 days but there may be certain urgent cases

that for whatever reason need to be expedited.

As I understand, the Knox-Keene code, there today is not an ability for the DOC to require a plan to step in, do something within 24 hours or a shorter time frame. I guess the point I'm making is, one, this is new; two, it really applies to a subset; and, three, today anything that is a true emergency there is immediate approval required by the health plans so that the member's life and the health status is not jeopardized. And those would be my comments.

MR. LEE: Other comments?

Rodney.

DR. ARMSTEAD: Just to follow-up on Ron's piece. I think that it would be probably prudent to really look at what DOC's intent was when they changed the rule basically saying that the emergent or the expedited process that they had was really, you know, the four -- five days. It wasn't working days, but it was just five days.

I think the point, too, about the 72-hour expedited is that we don't necessarily have enough information from the plans now as they are trying to respond to the expedited process on the five days. I think it would be -- and that's not to say it's an untenable task for me. But I think the rule basically tried to wedge the 72-hour piece in there from HCFA's perspective.

I think that the plans can work to

effectively try to balance that particular thing. And I think we just need more time to allow that to flesh out. And we might find that for HCFA five days is appropriate or we might find that three days is not a problem relative to this.

So I think that this one is really one to step back and just look at -- I think what existing law has done is really try to get the plans to respond and that the five days is just five days that excludes working days, but you really have to respond to that. I think it's the appropriate place to look at it. And I think that we have less of an issue of -- a cross plan issue with this particular piece.

MR. LEE: May I suggest on this one that an amendment be to have the regulatory agency look at how the 72 hours has been implemented compared to the five days and consider making the standard consistent in two years which would then allow the 72 hours to have been up and running for a while than have it considered as upgrading the standard.

CHAIRMAN ENTHOVEN: Good.

MR. LEE: Do people find that friendly?

CHAIRMAN ENTHOVEN: Uh-huh.

MR. LEE: Moving on to the minimum time stated for periods of limitation. Now this is one of the areas that we found an incredible inconsistency among the plans. Some plans will have as a matter of policy in their contracts that, if you do not appeal a

denial within 60 days, you waive your appeal rights. Other plans have no period of limitation. Other plans say a year. And this is one of the things where consumers don't read this fine print but can be left out in the lurch because they didn't know the turnaround.

So what we are recommending is that there be a minimum period of limitation. What we suggest is one year or at least a year, and even with that it's very important to have a good cause exception, that people didn't know, something came up. There needs to be a way to (inaudible) have a standard for an exception process.

Comments on what will become A3?

DR. ARMSTEAD: Peter, I have a quick question to understand the implications. Let's say that a patient is continuously -- let's just say -- this probably is a better example for a Medi-Cal patient who's enrolled in Plan A and transitions to Plan B and falls within the minimum criteria.

The question I really have is tracking the liability for that medical expense that may come from that grievance piece. Is it for the individual plan that the individuals have voted at that time or does it go back and apply to the plan at the time in which the condition was being requested for?

MR. LEE: It would always go back to the plans whose actions are being appealed. The problem

here is when a plan makes an action and the opportunity to appeal it to that plan -- it can't be the new plan that someone shifts to -- but to that plan, if they lose rights because they miss a time period, we're trying to have consistency with regard to that.

There needs to be a language that clarifies that this does not open new avenues of liability to a new plan that someone shifts to. I think that's certainly easy to put in. That would be a very friendly amendment.

MS. DECKER: Nancy?

MS. FARBER: I have a question about that, the example that was just given. If a patient has submitted a grievance in an appeal and then in the interim switches plans and experiences a similar denial for the same care, then they're going to be back at square one again. Is that not right?

MR. LEE: They may be back at square one. The concern here is not -- is to prevent a plan from saying you can't even go back to square one at all because you lost your rights because you didn't come back to us in a time frame. And this does not prevent a similar occurrence having a consumer able to come back in the door store and say something new or different or whatever. So the square one issue is somewhat of a separate one rather than having a shut door is what we're trying to prevent.

MS. FARBER: Presumably if you would

implement an approach like this, there would be less of an inclination on the part of the beneficiary to change plans. They might stay with the plan.

MR. LEE: Potentially. Sure.

We have five people on the list. And Alain first, then Phil, Rob, Tony, Michael, and we're going to stop there, do a straw poll on this and move on to the next issue.

CHAIRMAN ENTHOVEN: I think it would be crisper to take out "at least" and to say "one year with provision for good cause exceptions." Otherwise, if you say at least one year, God knows --

MR. LEE: The only reason we said "at least" is that, if a plan wants to get people longer, that's fine. And that's part of the concerns we're having on the floor is that as a matter of contracts all I could say, we'll waive that provision just to make it clear that a plan can do that. But I think that's a friendly amount, though.

MS. DECKER: Phil.

DR. ROMERO: There are really two components to your recommendation. One is consistency across plans and the other is a specific length of time. I completely agree with the first. On the length of time issue, I'm just curious, I mean, do we have reason to believe that lengthening the time would have materially reduced the number of complaints? In other words, is this a theoretical problem or a real

problem?

MR. LEE: I mean, it's a real problem. The extent of it I'm not sure. We've actually had people who we've -- had health risks. (Inaudible) through good cause know that this should not apply. How much does that happen when people do not have that assistance, I don't know. So the frequency is a question mark. It's one of those that came up again trying to look for consistency across the board.

MS. DECKER: In response to other kinds of plans like a PPO type plan, very typically you have one year to claim final limits. And I think we get a lot of pushback in our plans from people that find things two years later and want to file it and we look to a limit establishing that we know what a liability is in closed books.

MR. LEE: Ron.

MR. WILLIAMS: I think -- a couple of things I'm not clear on is how does this relate to the enrollee's ability at any time to contact the DOC with their dissatisfaction and file a grievance regardless of the time period?

The second issue is that it strikes me that 90 days is better than one year. In 90 days the amount of information that is stored, retrievable, it's fresh in terms of all the medical information. It doesn't have to necessarily be stored and be retrieved.

I think the other thing which might be

help is some consistent standard, perhaps the 90-day standard, and an affirmative obligation on the part of health plans at the time they notify a member of the finding that say you have 90 days to appeal this. And they make it very clear and very prominent.

I just worry that a year is a long period of time, and it just ends up addressing cost situations -- it could increase our cost without a real sense of the degree to which consumers will benefit. If we have a consistent standard, we have affirmative notification, the member always has the right to go the DOC, then I'm not clear what we're getting.

MR. LEE: Tony and then Michael.

MR. RODGERS: Are you saying during the time of coverage or are you saying that -- once a person loses eligibility for that plan? I'm talking about Medi-Cal where a person is offering three months and is going to grieve an action while they were on Medi-Cal yet they're no longer on Medi-Cal. And that creates contractual and other problems. Is that your intent, to say that they can go back to the time they were on Medi-Cal and grieve that and try to get medical care for that period of time?

MS. DECKER: And they're not currently eligible?

MR. RODGERS: They're not currently eligible. That's why I want to know are you talking about the coverage period for that plan or are you just

broadening it now?

MR. LEE: The intent was to go beyond the coverage period (inaudible). We hadn't thought about the eligibility issues for Medi-Cal. So I welcome clarifying language for that.

MR. SHAPIRO: I actually think we're creating more problems than we intended by this recommendation. All the questions that have been raised go on all the time no matter what period is in the contracts.

I mean, these are questions that are inherent. Whether it says 90 days or 1 year or 2 years, it's not -- the plans want to deal on a day-by-day basis now. While you were in a previous plan or with Medi-Cal -- that's not the point of this recommendation.

Plans currently have contractual provisions that differ substantially among the plans on the issue of at what point has an enrollee lost his or her right to file a grievance? That's the only issue. The other issues are still out there.

And what we've had -- and I don't know what the standard number is. It may be a year. But what occurs is if you miss that 90-day deadline or 60-day deadline, you have just waived your right to complain to the plan. The question is should there be some uniformity with respect to that period?

The other issue I don't believe this

recommendation goes to and all of a sudden we should be talking about in terms of what if you switch plans or those kinds of things because that happens now, those issues are resolved on a case-by-case basis.

The other issue in terms of special circumstances which have come up is sometimes people don't discover the problem until a later time. And there have been exceptions allowed by courts that they allow you to go beyond that period if, in fact, a prudent person wouldn't have known about the problem until a certain point; and, therefore, it would have been unfair to prevent the patient from bringing the issue.

Once you've brought that complaint to the plan, then all of the other deadlines kick in, 30-day response period, 60 days after that you can go to the regulator. This really deals with the question of, at a certain point, have you waived your right to start the process? And should there be uniformity?

And I think the rest is things you shouldn't try to resolve. We have no background on it. We don't know what the problems are. They're inherent no matter what the deadline is: 3 months, 6 months, 1 year. If you change plans, all those things are current problems.

MR. LEE: Steve, and then we're going to do a straw poll.

MR. ZATKIN: I agree with the concept of

uniformity. I'm a little uncomfortable with the specific proposal about a year. And I'm wondering if it would be appropriate to have the paper reflect support for the concept of uniformity rather than get into the specifics of the time period.

MS. DECKER: And leave it to whom to establish?

MR. ZATKIN: The Legislature because it would have to be addressed.

MR. SHAPIRO: I'd rather (inaudible) because people argue that we micromanage. I would direct to authorize uniformity, and you'd get the best practice plus the exceptions because we haven't developed them here. But you make a committment to that uniformity.

MR. LEE: I think that's a friendly amendment. With that amendment, can this be submitted to the regulatory agency for a rule making process to have consistency across in terms of this area with the one notion of Ron's being this should have no impact -- it should be made very clear -- no impact on the deals (inaudible)? This is relative to plans contracted to having to waive their rights for their plan process. Okay?

The next area is terminology and data collection. This is a recommendation that there be basically common terms used, which there are not right now, and the known standards on how data and types of

data is collected. This relates very much to Recommendation E, which we'll get to, which we'll get lots of comments on, I'm sure.

One of the problems right now is you really can't compare data between plans. Purchasers can't say what's going on in your plan relative to complaints and grievances and compare it to another plan because each plan collects data very differently.

This recommendation is, again, to develop such standards in a collaborative process, but the end point would be to have common definitions that would allow for comparison between plans.

Comments?

CHAIRMAN ENTHOVEN: Make it "the regulatory agency should develop."

MR. LEE: The state would be substituted for the appropriate regulatory agency that tracks throughout.

DR. SPURLOCK: Just a quick question. Has there been any idea about the cost of this and how much the data collection process goes on and what would be given up in order to collect the data?

MR. LEE: I think all plans and I think the vast majority of large medical groups do data collection. The question is what would be the cost of changing data categories and making those consistent? And I'm not sure what those costs would be in terms of having such a process phased in over time would be

something that I think the rule makers should look at. But I think every plan collects some data like this currently. The question is they don't use the same category.

DR. SPURLOCK: I guess what you're saying is this is not the regulatory authority collecting the data, this is the individual plans collecting the data.

MR. LEE: This is the plans collecting the data but using common data elements.

Without objection, is there any strong objection to this?

None heard. Moving on.

The next is communication of processes. Currently plans are required to give some notice of -- hold on a second. Really, the communication process -- C and D are sort of the common recommendation. First is there needs to be a clear description to consumers of how dispute resolution works.

The other element is on request to provide well prepared appeals. One of the things we found is that consumers don't even know how to state a case and don't know if they've got a loser or a winner and to have plans provide this is how you support your case.

The second part of C I would like to pull out it was brought up earlier which is the make practice guidelines available. This really is a separate issue which I strongly support. But it's a

separate point from the information giving someone a example of what a good appeal package would look like.

DR. ROMERO: So you're suggesting ending C with the word "request"; right?

MR. LEE: "Upon request."

DR. ROMERO: Right.

MR. LEE: Exactly.

MR. SHAPIRO: I have one comment, Peter. It's not always in a plan's self-interest to give you a model appeal, good or bad. And including for uniformity, just models -- actually, DOC puts out a form that says, you know, tell me the facts, tell me what your doctor says.

One suggestion is to have a regulator just do a model consistent form which could help even a bad or good case rather than people complaining that the plan didn't really give you the best grip. It takes the plan off the hook for what really aren't bad appeals. And they do by letting the regulator work with the plan on one single model form that might be appropriate.

MR. LEE: I think that's a great suggestion. The only one thing is to prepare sample of model appeal because there are different issues that people have appeals on. There isn't necessarily one model that comes across different sorts of issues in any way.

CHAIRMAN ENTHOVEN: Sure.

MR. LEE: Okay?

CHAIRMAN ENTHOVEN: No objection.

MR. LEE: Without objection.

Full explanation of health plans' decisions. Now some of this is current law. What is not is the level of detail that's being requested in terms of the information that was reviewed in making the decision, expert opinions.

And I'd also like to insert in there "or guidelines relied upon as well as information and instructions on how to appeal." And there is while current law says there must be an explanation on the basis of a decision, often that explanation is in the form of a one-line "determined not to be medically necessary," which does not provide a sufficient basis upon which a consumer can understand what went into this decision. So this is providing more detail which would provide consumers with information upon which to decide this was a reasonable -- or to know what issues they need to address.

MR. WILLIAMS: One question I'm not clear on is how this affects the peer review process. I know one of the big challenges we face is the inability to be as descriptive we would like to be relative to some of the peer review guidelines that the medical groups impose. I wonder if some of the physicians might be able to comment on that.

DR. KARPF: That is rather important to

me. I think that when we start getting into issues of definitions of medical necessity, evidence-based medicine, experimental medicine there is no real clarity, there really is no real definition.

I think one of the things we've been trying to do is bring to the process of managed care and health care in general some clarity, some definition, some accountability. If we're going to be successful, we're going to have to get to some level where those terms have some meaning and some understanding.

So I think that it's an issue of us essentially coming to some recommendation where there is some process by which these terms are dealt with, medical practice is dealt with, whether that is an expert panel that's convened by --

MR. LEE: We did that before you got here this morning. We're having a blue ribbon panel to come up with the common definition throughout medical necessity.

DR. KARPF: If that is -- well, that blue ribbon panel is going to deal with medical necessity, appropriateness of care, evidence-based medicine -- all of those issues?

MR. LEE: We need to look at the language in there. There were a number of pieces being looked at including medical necessity. I'm not sure about the whole laundry list.

CHAIRMAN ENTHOVEN: That's purely terminology. Michael's concerned about this other question which is when there are wide variations of opinions, how do we get some authoritative determination as to what is either medically necessary or whatever other terminology we use.

DR. KARPF: And sort of the empowerment of this blue ribbon panel kind of saying here's the blue ribbon panel that's going to make some comments versus the ability to develop some standards, the ability to use precedence to say this, in fact, in California is considered standard of practice or isn't considered standard of practice or this is considered experimental or isn't considered experimental.

MR. ZATKIN: Isn't that what the external panel issue will deal with?

MR. LEE: That's what the independent third party review would address. The substance, what I would say is that the blue ribbon panel would be defining a common definition of medical necessity but not getting into any particular cases or defining what is or is not experimental. I think that issue that we're addressing in the external third party review for medical necessity dials delays, et cetera.

So in terms of this issue, though, in terms of the full description, are you raising concerns or amendments to --

DR. KARPF: No. If we're going to bring

it up later on where I thought we were going to bring it up and my comment is marked, that's fine. But I think they become fundamental issues no matter how you set up the grievance process. If, in fact, you're not working off of the standard definition, if there isn't clarity of thinking, the grievance process doesn't end up working.

MR. LEE: Bruce.

DR. SPURLOCK: Just responding to Ron's question. Looking through the language, I guess the only area that rings a great deal of concern to a level of detail that's important is any expert opinion relied upon in that language.

And I guess there may be expert opinions that are done on an anonymous basis simply because it's a peer review process between clinicians and that we'd say that they're going to necessarily be made public, then the folks may not generate those opinions for a variety of reasons. So I guess that would be some of the issue.

I think maybe what Ron is getting at is there may be a detail that's not actually included in this language that would be speaking to the nature of individual physicians who are part of the decision process that may be either disparaging or some act on that physician that has some impact on his practice of medicine.

I think we want to be careful about it.

I don't necessarily read that into it. But the expert opinions, demanding that they are public I think may make a lot not offer expert opinions.

MS. DECKER: I think the intent here is not to quote the opinion but to say an expert opinion was sought and used, the fact that it was reviewed in a different way.

MR. LEE: I think that we would certainly -- a friendly amendment would be in no way that would intrude upon, you know, process of protection by current peer review law statutes. Adding that would be a friendly amendment.

DR. GILBERT: We're focusing on a subset of grievances, though. I think Ron's point is extremely important for certain other kinds of grievances. If the grievance is about a quality of care issue or a potential quality of care issue, then, depending upon the level of detail that's required, it could absolutely impact the peer review process.

And it's very tricky about how you respond and how much information you can give when the grievance is about quality of care. When it's about a utilization review decision, it's actually much, much cleaner and they're generally not peer reviewed issues potentially at risks.

But any time quality of care is raised, whether it's my physician didn't or provider didn't do this kind of physical examine or didn't ask these

questions or gave me bad care, it's very, very difficult to figure out the level of detail you can give without violating the peer review process. If you violate the peer review process, you're not going to be able to take the action to do the work you need to do to improve that.

So this seems so focused on UR decisions and appeals. That are a whole other set of grievances that occur, many of which are on quality of care. This language is almost irrelevant to those, and yet depending on the level of detail you want, it may be a real problem.

MR. LEE: Bernard and then Michael.

DR. ALPERT: To respond to Ron's question about how physicians feel, at the risk of incurring the wrath of my fellow physicians, I personally think there is incredibly too much paranoia that surrounds peer review.

When I look at how much is disclosed now versus the potential of what could be disclosed, we're way, way, way on one end of the spectrum. I support the revealing of more than this was found out to be medically necessary. It's like doing risk adjustment, adjustment based on gender and age. there is another level we can go to now which will be a big step. Expertise is what I'm referring to.

The case I cited before about the eight year old with Hodgkin's disease, the reviewer was a

retired surgeon passing the review on the pediatric oncology case. And that was never disclosed. So they're very simplistic based on things that could be disclosed other than this was found not to be medically necessary.

MR. LEE: What I'd like to propose on this is, without objection we get some language to qualify appropriately protected peer review data, and I'd be happy to talk to some of the doctors about that when we come back for a vote here. Without objection.

Please.

CHAIRMAN ENTHOVEN: We have now consumed one hour of the two hours allocated to this; so we need to --

MR. GRANT: Peter, I don't have objection to that particular issue. I wanted to amplify on a comment that Bruce made which is I'm concerned that the quality of care type of complaint is really not addressed here and that -- particularly the circumstance where the dispute may arise between the patient and physician as opposed to the physician and the plan. It should either be addressed by implication or stated in some way here. One should be entitled to information about grievances and so on when the issue is really whether wants to give you something you don't want or vice-versa.

MR. LEE: Without objection, moving on.

We're going to need to, believe it or

not, figure out how to speed up. I know this is difficult. There is a lot here. We didn't try to throw in the kitchen sink, believe it or not, but this is, we felt, a lot of the areas that the Task Force can make a huge contribution. I will, though, force us to keep comments very brief and do straw polls if we have to rely on that to move things along.

CHAIRMAN ENTHOVEN: A good device would be to refrain from wordsmithing. Just get the concept.

MR. LEE: Again, words are welcome for submission for smithing later.

Public reports. This is an issue that we, one, I'd like to reword this to note the health plan regulator would develop this obviously following the standardization of terminology and phase it in over time after working with the array of stakeholders including plans, medical groups, consumer groups.

The important note in terms of getting comments on this measure, virtually everyone thought it was a great idea. The concern came from plans that were quite concerned about comparability and being misleading if it's not comparable. I think that everyone agrees with it. I certainly do.

So the issue that this should be implemented at such time as we can do it in a way that provides reliable and comparable data is the intent. And with that I'll throw it up for comment.

CHAIRMAN ENTHOVEN: Okay. Without

objection.

MS. DECKER: Without objection.

MR. LEE: Without objection, we're moving on.

MS. DECKER: Page 4, F.

MR. ZATKIN: I forgot what we did because I was reacting to your amendment to this. You were -- your amendment was that you wanted the agency to develop a process in which additional information relating to grievances and appeals could be made public and that the amount and nature of that information would be developed based on standard definitions and the capacity of providing the information as well as the burden of doing so and usefulness of the information -- is that what you were suggesting? Or am I putting words in your mouth?

MR. LEE: That end certainly was. And the intent is to have the data that's made public be reliable and comparable. And those test points or those that are key measures would require this to be phased in over time with the leadership of the state regulatory agency.

MR. ZATKIN: Were you then going to be specific as to the nature of the information or leave it basically to the agency to work to develop that?

MR. LEE: I think it would be developed by the agency in collaboration and the types of materials listed here would be by example. When I say

"here," currently listed in Section E.

MR. ZATKIN: I was with you until the last there.

MS. DECKER: If you look at the top of 4, it is a summary that says the number, type and disposition of issues raised by condition or type of complaint sorted by medical group and then on the top of 4 it gives more detail.

MR. ZATKIN: Well, if you were to put that list and proceeded with sort of a question as to whether this could be done in the manner that we talked about earlier, that would be okay.

MR. LEE: That's what I think we do. This list is a by example and not prescriptive.

MS. DECKER: Things to be addressed.

MR. CHRISTIE: On the subject of public reporting, one of the issues that comes to my mind very clearly based on my experience is that in my experience plans have no reason to bring grievances to a rapid or quick resolution. There is no outside requirement.

And as we expressed in our case, our grievance went on for a period of 120 days which then filtered into an arbitration process which went on for another 3 months. The whole process took us over 11 months. If there were some way that plans were held accountable for the amount of time it takes to go through the process, the grievance process is an all-inclusive word.

It includes the actual letter writing and the peer review within the plan plus the arbitration process as well. That is the overall grievance process. I think the plans need to be held accountable publicly for how much time it takes to complete the grievance process. And we have no access to that data today as to how long a plan takes to complete that process.

So I want to see language in there that says something to the effect that grievance processes which include the arbitration process, the results of these must be made publicly available.

MR. LEE: If I could, I'll have on there two things. One is that there is a block of recommendations related specifically to the arbitration process that I'd like us to carry over to our next meeting because I'm sure we'll run out of time but also because Martin Gallegos is not here today who submitted those.

I think some of those issues were specifically covered in there. We currently have a requirement that plans report longer than 30-day complaints in handling. And I think a suggestion that we can add to the list of data to be considered for reporting is length of time to resolve. And that was addressed on the complaint side. The arbitration side addressed it elsewhere. Is that okay? Okay.

F. F is basically very poorly worded if

I may say so. I probably worded it myself. But the intent is to provide notice of where there are external assistance programs, that people should get notice of them. The type of those is talked about later. This is a consistency that people should be notified that they exist.

Without objection.

H. One of the issues that has raised the most confusion is wanting clear government oversight. The intent here is not to have -- to supplant the discussion that we're having about government oversight on health plans but, rather, from the consumer perspective there needs to be a single point of entry.

Right now consumers do get ping-ponged back and forth between DOI and DOC. And the intent of this recommendation is to have -- if you have a question about your health plan and want to complain to a regulator, here's a 1-800 number.

How that is behind the scenes triaged between one or two oversight agencies is a separate matter, but the intent here is to not have multiple numbers out there. People don't know if they're in PPOs or HMOs.

Comments? Any objections? Hearing none.

Moving on to Barbara taking the chair on the next set of recommendations.

MS. DECKER: Page 4 under "Consumer Empowerment." The first item -- again, let me restate

that all of this is done in a collaborative manner where we would have key stakeholders involved in developing the specifics.

So under A the first item is talking about notification of the member whenever there is a disagreement with the decision. Now, this is very difficult because we can't figure it -- it's a challenge to figure out, when is there a disagreement?

But I think the intent here is to make a strong statement that it needs to be incumbent on every entity dealing with consumers in the system, that they be aware, when there is a dispute, that they advise them of their rights.

Is there any comment on this item? I'm on 4A.

MR. ZATKIN: I have a question. So I walk into my physician and I say, "I think I have strep throat and I would like you to give me antibiotics," and the physician says, "I really -- you know, you may, but if I give you antibiotics right away, it may cause -- there will be no resistance." But I think we really ought to culture that. So we disagree.

MS. DECKER: We're trying to foster an environment where we address issues at the first possible instant. If you disagree, you're a provider and the patient is saying that, I hope you take the time to explain and say, "If you don't agree with my treatment suggestion, here's an alternative of what

else you can do at this point." But this is the conceptual mode we're in. Do you have an alternative?

DR. SPURLOCK: Barbara, I think that's a key point that we need to keep throughout the remainder of this. Usually it's not a denial, it's a treatment alternative, one alternative if there's no treatment for strep throat or suspected strep throat. It's not -- I mean, it's not necessarily always denial, but it is alternatives.

I think it's important at every level for the alternatives to be available. It's just a question of when do you invoke all of the other things? At what level of medical condition do you invoke the process of all the levels of alternatives.

MS. DECKER: Any other comments? Ron.

MR. WILLIAMS: A couple of questions regarding jurisdiction, if you will. One is I'm not sure how this affects TPAs, third party administrators, the PSOs and the employer themselves to the extent that they are currently (inaudible) information about the plan and the employee has to file a grievance about that. How do you envision those entities being covered under these issues?

MS. DECKER: What we're trying to do is improve the communication and it may be with a TPA or a employer that the first step needs to be to direct a person that is asking the question to a resource of where they can get clear information about that issue.

For me I would say, "Have you looked at your summary plan description? It's on page whatever and it describes this?" It's not trying to make the system paper intensive. It's more trying to get information to the consumer as soon as an issue comes up.

Different kinds of plans obviously wouldn't have this interaction at the same point. I wouldn't expect somebody to call their PPO and say, "My doctor wouldn't give me a lab test for my strep throat." It's a different kind of world.

MR. ZATKIN: I have to say upon reflection in reading the full item that I don't have a problem with it. Forget what I said.

MR. LEE: If you do, the A and B really spelled out that we are not trying to overpaper doctors that have papers, get written bills and rights when they're talking about treatment decisions. But instead have a point at which a group, some entity makes a decision -- that's the point at which something in writing kicks in.

With that, 4 A and B, any other comments?

MS. DECKER: We're including B now which is at the top of 5.

MR. LEE: They really need to be seen as a group. You have 10 just to keep decisions and disputes resolved at the lowest possible level and the second is to give notice when a quote, unquote, "regal," if there is fuzziness there, an incident

occurs, to give people notice and include it in writing.

MS. DECKER: As we just led into B, I want to point out B includes something in italics that I think deserves your special attention. And this says that plans should be required to take for second opinion within the consumer's health plan, which is different than I think a lot of plans have today where it's within their own group if it's an HMO type plan.

I think Bruce had a comment.

DR. SPURLOCK: Just a real simple thing. Would you consider this friendly, at the end of the line should be in writing "upon request"? Maybe every consumer doesn't necessarily want that writing so that would only be done for a consumer who wants that and requests the writing.

MS. DECKER: Tell me again where you are, please.

DR. SPURLOCK: The top of line 5. It's a simple thing. If a consumer wants it in writing, great; if they don't want it in writing, big deal. I think if they're satisfied with an oral description, then why do we want to put it in writing?

MS. DECKER: Sure. Anything to make it faster.

DR. SPURLOCK: If they're dissatisfied, they can always require it in writing.

MR. LEE: With the orally notified, they

can get it in writing. I mean intent is to communicate, if you want this in writing, you can get it in writing but here's what it is.

MS. DECKER: Any more comments on this item?

MR. SHAPIRO: Are we doing the italicized provision yet?

MS. DECKER: Yes.

MR. SHAPIRO: I believe I sent written comments to indicate the caution on this, this is an issue that is subject to pending legislation on second opinions, that I found the language here too narrow relative to current industry practice where if there is circumstances where a second opinion is appropriate, it's not limited at least under the pending legislation to either the medical group or the network if there's not a qualified individual in the medical group or network in which case the plans have been paying for second opinions outside the network but you have to jump over those hurdles first. So I have found no exception in the general rule here.

MR. LEE: I think I mentioned a friendly amendment of health plan or outside their plan if the expertise does not exist within that plan.

DR. KARPF: Who decides who has the expertise?

MR. SHAPIRO: It's grievable.

MR. LEE: That is one of the medical

necessity type questions, whether or not the second opinion is an appropriately qualified --

DR. KARPF: In my 20 years of practice, when people came to me and said, "I want a second opinion," I encouraged them. I said, "Just get a second" --

MR. SHAPIRO: Marjorie won't take credit for this, but my first reaction is I'm not sure why this second opinion issue is in this paper. I just point that out as a --

MS. DECKER: We actually had a number of comments that felt it should not be within the dispute resolution process paper. Personally I feel that second opinion has the potential for resolving disputes at a fairly early point in time instead of having things be carried through a laborious grievance process. So if a patient, Dr. Karpf, goes to get that second opinion then feels like they're getting appropriate care, it kind of diminishes the tension and hopefully moves on without a grievance.

MR. SHAPIRO: I'm comfortable as long as we get that qualification (inaudible) --

DR. RODRIGUEZ-TRIAS: A question to Michael, as I understand yours is that the plan pays for the second opinion irrespective of whether it's inside the plan or outside the plan?

MR. SHAPIRO: If you look at the November 17 handout that I walked around and put on

everybody's desk, No. 3 on the first page, I mentioned at least based on the oversight of the Legislature, the general industry practice is they can limit second opinion referrals to their network providers. That's the general rule. And they pay for that.

But it says unless there is no independent qualified network provider, in which case approval has to be given from out of network provider and in either one of those cases (inaudible).

My only concern was you couldn't limit it to the network if, in fact, you're dealing with a second opinion on a specialty and there's no specialist in the network on that issue, you have to pay for an out of network specialist.

DR. SPURLOCK: I agree with Barbara. I think the second opinion has great opportunity. Before doing it, I think we do need to tighten up some of the stuff that Michael just mentioned. I think it's worthwhile. Actually, though, I think the second opinion should go within the plan of network first to see whether they can resolve it. And if there are two people that agree there's not the expertise in that group, then it could go out and we can include that in how we do external review processes. But, I mean, you should keep it inside the plan, the network or the medical group as much as possible. 99 percent of the times they can do that.

MS. DECKER: I didn't quite hear the

staging.

DR. SPURLOCK: I guess what would happen is we need to expand on what we mean by second opinion. Take a lot of what Michael has said. We can say we encourage second opinions within the medical group network plan. And in which cases there are not the expertise, then you go out and the plan pays for those in all of those situations.

MR. LEE: The point is to encourage closest level resolution whether it's with a doctor in the group, in the network and it's only where there's not that expertise to this particular case where they can go out.

DR. SPURLOCK: Who determines when they have the expertise? We should start within the medical group. That's an important point. Because every patient might want to go to the Mayo Clinic even if they have a sore throat.

MS. DECKER: Moving this forward, without objection, we're going ahead with A and B and we're moving forward to No. 5. Consumer assistance through the plans. And what we're trying to indicate here is there needs to be -- obviously the best place to resolve problems is within the plans themselves or within the medical group, the lowest possible level.

But we need a real commitment on the part of plans to ensure that they're supporting dispute resolutions processes and educating their members about

how they work. And then we're recommending that accreditation and quality audit standards should require plans to demonstrate how they support consumers in working through this process, how are they proactively educating, sharing the information with them, et cetera.

So it is a recommendation of plans to, private industry groups that are auditing and crediting, to look at this particular aspect included in their survey.

Any comments here? Marjorie.

MS. BERTE: I have a question. The second sentence of 5 says, "Physician should serve as their patient's advocate," but we just went through a whole impression about a patient might disagree with his or her own doctor making it inconsistent internally.

MR. LEE: I certainly don't think it's inconsistent in that the aspiration, as I and most doctors would know, in most cases they do bill and serve as their advocate. There may be occasions where patients and doctors disagree and there needs to be a safety valve. So I don't think that the shoulds contradict that.

MS. BERTE: I just think we know the physician is the patient advocate and just state that in here. The problem is it goes further than we need to given that the dispute may or may not arise or

(inaudible) strike the sentence.

MS. DECKER: Is this a sentence of concern to folks?

MR. LEE: David.

MR. GRANT: I could suggest you could reword it something along the lines of can serve as an important patient advocate because that would echo the comment that oftentimes a dispute may be between the patient and physician.

MS. DECKER: I consider that a friendly amendment. Any other comments on 5?

MR. CHRISTIE: Barbara, just a quick one. Could you expand little bit on what you mean by adopt best practices, as to how you would portray that with respect to clients?

MS. DECKER: I lost where we are.

MR. CHRISTIE: That's right under 6. Am I jumping ahead of you?

MS. DECKER: Yes.

MR. LEE: Without objection on 5? Okay.

Six.

MS. DECKER: Here we were trying to serve as a bully pulpit I guess and say that we have seen some great examples in the information that we received within this Task Force of how plans can address members' issues. And we mentioned two of them here.

We know that state law requires experimental investigational treatment review with

external experts, but we'd encourage this because we think it adds credibility and comfort levels for consumers to know that plans do go outside their own panel to get information on unique cases that require highly specialized data.

And, second, we also said that -- we conserved a variation in the responses we got about patients or consumers being involved in the appeal process. Some plans don't have them involved in person at all and others provide for it in certain circumstances and others enable it in all case.

And we feel it's an important confidence builder in the process to have consumers present at least through a teleconference capability whenever possible when a dispute is being disputed at the plan level. These are just examples of trying to encourage the industry to move forward in this area.

Any comments? Rodney.

DR. ARMSTEAD: Barbara, just a quick question on 6B. What is your pleasure? Are you more desirable that we move and encourage the physical presence of the member there or are you saying at least by teleconference? Because one of the things -- I just want to understand what it is that you want. Because when you put teleconferencing (inaudible), that's the way they've always been or the majority -- I just want to ask the question in just the way it's worded.

MS. DECKER: Our intent was to be

inclusive, to let the member who has a complaint participate. If there are issues where the plan or the entity that is here in the complaint feels that the member should not be there or logistically it's not appropriate, then a teleconference is a good example of a way to accommodate.

We're not advocating that they be at every meeting. It's up to the patient. If they don't want to be there, that's fine. It's more of a participation of a member at a time.

Yes?

MR. LEE: I agree to state it more clearly. The preference is that members participate in person. One of the things we know is there's a creative thing where members were described either violent or being abusive, some plans said they will never get in. They won't be able to participate.

Other plans said for them we'll set up a process where they can participate by teleconference. So even in situations where rather than not have people in person, to at least let them do it by teleconference.

So the intent is, I think, to absolutely have people be in person but where that is not possible to set up creative ways to provide members' presence otherwise.

DR. ARMSTEAD: Let me suggest a different word in which -- the way it (inaudible) -- it's like

the industry is not allowing. What would be more in the spirit of what you're trying to accomplish is encourage member participation via either their physical presence by teleconference -- I think that's really what you're trying to speak to -- rather than from a perspective where they've been disallowed up to this point which in some circumstances had clearly not been the case.

MR. LEE: Right. Friendly amendment.

MS. DECKER: Without objection, we're moving through 6 then and on to 7.

Number 7 talks about providing --

MR. GRANT: Excuse me, I had a hand raised on 6.

MS. DECKER: I'm sorry.

MR. GRANT: We proposed the language to add a C to 6 which would allow the ombudsman service to assist people in all stages of the review process.

MR. LEE: State that again, please.

MR. GRANT: We provided a paper on dispute resolution which would be in the back of Item No. 6 which would be C to this. I think it's a particular concern that we're focusing on having members attend the process that they ought to be able to have someone there who can help them with it.

MS. DECKER: Unfortunately, I can't find your piece of paper. So this was just used as an example of a best practice?

MR. GRANT: Right. We felt that would be another important example of a best practice.

MR. LEE: Would you read it.

MR. GRANT: Sure. "Health access recommends that the ombudsman service be available in every stage of the process" --

MR. LEE: Are you talking about No. 7 now?

MR. GRANT: This is 6.

"Health access recommends that the ombudsman service be available in every stage of the process from initial inquiry through the (inaudible) to the regulatory agency to litigation."

MR. LEE: I think that is your No. 6, but I think that really relates to amending draft No. 7.

MR. GRANT: Fine.

MR. LEE: Which is fine. We'll get to that in one second. That's not from a best practice recommendation. That's the scope of services provided by an external ombudsman; is that correct, David?

CHAIRMAN ENTHOVEN: We've spent too much time on 6 already.

MR. LEE: 7. In No. 7 we're talking about those consumers that have been unable to effectively navigate the system as it exists, that they have some external entity to use as a resource. It could be in various levels of detail. The write-up talks about developing and distributing educational

material, providing referrals to existing resources, brief counseling and advising of prep problem resolutions.

So to be sure this is clear, this is outside of the plan. It's some entity that a consumer who can't figure out how to make it work has tried various things within the plan, has talked to the medical group, talked to the employer, can't get there, has another entity to go to to help them figure out how to make the system work for them. It's not a body that can make a decision for them. It's to help the consumer work the system.

Any comments? Bruce.

DR. SPURLOCK: Thank you, Barbara.

My only comment is the level of detail is extremely critical about what the independent program is. I actually supported the concept wholeheartedly, but the level of detail in the activities go to the italicized portion which is the premium tax to pay for it.

If you have one that's extremely broad based and involved, you can add to the premium of the member dramatically, if you have one that sort of helps go along the way and sort of intervenes when necessary. So we get a cost benefit tradeoff, the cost of the service versus the benefit applied.

And my concern is that until we know that detailed level of information, the broad education

programs which are hugely expensive are effective, I think we should start with a simplified assistance program for people that have guidance on navigating through the system and then add on educational programs and other activities as we understand that process better than the cost critical relationship. That's what I would do. The premium tax is going to raise the cost. If it doesn't come out of the actual health care dollars, it comes out of the dollars somewhere.

MS. DECKER: Michael?

MR. SHAPIRO: I'm afraid I wasn't carefully listening, but I heard "dollars." I am concerned and it's unusual for me about spending government dollars, but if you look at Recommendation No. 4 in the November 17 handout, the recommendation in the paper has an italicized reference down there of how we should spend money --

DR. ROMERO: Michael, what are you referring to?

MR. SHAPIRO: First of all, I'm just reacting to the language at the bottom of 7, which is in italics, a separate stand-alone suggesting that we're going to spend premium tax or other funds on this issue.

In my written recommendations to you, No. 4, what I suggested was some pilot efforts with private foundations as well as government funds, that we not jump too quickly into spending a lot of money

until we know -- there is only one pilot currently in existence in the Sacramento region that deals with these issues thoroughly. It seems to be Southern California and others, maybe one or two more.

But I just throw a caution that we might want to support some pilot efforts with some modest funding before we get too far ahead and then see what works.

MS. DECKER: So I heard pilot efforts with modest funding perhaps from --

MR. SHAPIRO: The language I'm proposing is on the November 17 memo, the first page, No. 4.

MS. DECKER: Right. And it's underscored.

MR. SHAPIRO: As an alternative to the italicized language, which is sort of open-ended about spending premium checks.

MS. DECKER: Other comments?

MR. GRANT: On this particular issue, two brief points. One is the use of the word "brief." As anyone who's worked in public advocacy knows there's no such thing as brief counseling. I think the existing network of high cap programs across the state indicates a number of different types of local efforts to do advocacy for clients which goes beyond the brief counseling stage. So I recommend that that -- that's a good point to peg as the middle of the continuum of advocacy support services but not the end.

Second, I think the advisement of problem resolution part would go to my comment for the previous recommendation, No. 6, which is that support for numbers should be provided at all levels of the process. We are after all dealing with particularly the elderly and frail population, Medi-Cal, often non-English speaking people who are not adequate to be consumers -- consumer representatives for themselves as well as face the panel of professionals provided by the health plan.

So this recommendation, I think, needs some substantial strengthening along both of those lines, that is, that the counseling part be expanded to include representation and that the continuum which is described be expanded along the lines of the recommendation that we've submitted to the members of the panel today.

MS. DECKER: I didn't hear -- the item you're referencing is in your letter of November 23?

MR. GRANT: Yes. Item No. 6.

MS. DECKER: Which says the ombudsman services to be available at this stage of the process from initial inquiry of the complaint to the regulatory agency to litigation?

MR. GRANT: That's correct.

MS. DECKER: Marjorie.

MS. BERTE: To raise a point on this one, a lot of this is currently the responsibility of the

state regulatory agency. If you go through the processes you've outlined above, in terms of standardizing, creating consistent tracks with consumer information about the steps in the process for grievance resolution, if you go with the final sentence of this which basically would indicate the status, going to farm this out using premium tax dollars to private entities, then you may be creating a great deal of redundancy with what the state agency is doing.

I would further comment that one of the most valuable sources of information for us as a regulator is patterns of problems that individuals have in the marketplace. If you're the health plan regulator and find lots of consumers are having difficulty with a particular health plan or any of the other groups because their processes are difficult to get through, they don't know how to get through them, that triggers, at least from a regulator's standpoint, a further review of how well consumers are able to get through those processes that are mandated and that should be accessible.

So if you balkanize this, make some of it private with some reports and some of it is public regulatory agency, I'm not sure you'll move in the direction of efficiency and effectiveness from an enforcement perspective.

MS. SINGH: Time check. We have 27 minutes left.

MS. DECKER: Ron is next.

MR. WILLIAMS: I think this is a very good idea in terms of ensuring that consumers have access. I have a couple of concerns. One is I think there is a need for some kind of pilot process. I think the other thing is really the impact on the uninsured.

You know, I don't know if you've scored up the cost of everything we've just decided today. But we've added quite a bit in the cost of the premium and decisions that represent very important issues, tough decisions about what the industry should and shouldn't do.

And I think maybe the best example we should think about is maybe the workman's compensation area where we've created incentives in an effort to make certain that every worker does have access, to be certain that, if they're injured, they're getting the right level of compensation. At the same time in doing that, we created some pretty perverse incentives that dramatically increase employers' costs.

MS. DECKER: We have Peter then Steve Zatkin and then Bruce.

MR. LEE: You'll note that I -- Barbara will facilitate this because I'm in somewhat of a conflict of interest so to speak being -- running one of the -- the only program that's right now doing this in the state. A couple of comments.

First I think we've certainly seen from the survey done in the Sacramento areas, the one that was done statewide, that consumers are not fighting the state regulators and consumers do need independent assistance. I think it is a good idea, though, to do pilots, and that's why I'm doing one here.

I think Michael's amendment is a friendly amendment. I think also that David's suggestions are very good in that the questions of, one, how people always help the process is essential. The other is what elements of service get tested is very important.

And I think noting the sorts of services that need to be evaluated -- we list some and I think it's a friendly note to pull out grieve and including potentially through litigation is an important addition, not saying that every program would do it. Our program doesn't.

The high caps which are the programs that serve Medicare beneficiaries in the state have that capacity. The long-term care ombudsmen have the capacity actually through litigation. How do these issues play out differently is why you need pilots to assess how do you have a program that actually contributes as effectively as possible. And then we can weigh the cost benefits of such a program before you roll out and say, "Now let's have it for everyone in the world."

MS. DECKER: Steve Zatkin.

MR. ZATKIN: I would support the pilot approach for the reasons noted because I think we're basically going to be funding three layers: internal patient assistance, regulatory assistance and external ombudsmen plus possibly external review. This will add an impact on cost.

MS. DECKER: Bruce. Last comment.

DR. SPURLOCK: I agree, as I said before. I have one problem with the litigation portion, Peter. I think there is inherent conflict of interest on that issue. I think the pilot shouldn't necessarily do that issue because the folks that actually take to litigation have it inset early on not necessarily to improve the process but to take the issues as they see it to their best interest. So I think leaving it out as you've done in Sacramento is really a brilliant strike. And we should keep that throughout and take out the litigation aspect because I think it's an inherent conflict of interest under any pilot.

MS. DECKER: What I'd like to do on No. 7 is to reword this as a pilot per Michael's language. And without objection, proceed to G.

Do we need a straw poll?

CHAIRMAN ENTHOVEN: No. No objections.

MS. DECKER: Now Peter will go on to independent third party review.

MR. LEE: Diane.

MS. GRIFFITHS: Concerning the

independent review section, I find it corrects some inaccuracies in the current law. I gather from talking to somebody that you're aware of some of them.

MR. LEE: Right. There have been a number of pieces that are not reflected accurately in terms of -- in particular the applicability of the third party review for experimental treatments cutting across, and that's something we need to clarify between now and the next draft.

MS. GRIFFITHS: The provisions of AB 1663, which are noted in A, they limit the third party review only to experimental treatments involving terminal conditions; so a breadth of that provision is overstated in the proposal.

And also Footnote 9 is inaccurate. There is no dollar threshold which determines whether you get a three-person panel or an individual panel.

MR. LEE: Again, on other technical amendments, I welcome them to be submitted both either now but ideally after, too.

MS. GRIFFITHS: I just think the first one kind of flavors the whole discussion.

MR. LEE: The note on this is the decision to have a safety valve and the proposal here is to have a safety valve that would still have patients seek to resolve their problem with the in plan procedures but allow an out to a qualified decision maker that would make a decision relative to the

medical necessity issues or to denial, delay or terminations of medical care.

This has been -- a program similar to this has been recently put in place in about 14 states. It's one of the things that the President's commission endorsed. I think there are a number of key questions that are outlined here in terms of what are the scope? What gets you in the door? That we need to flesh out a little bit.

We will never be able to flesh out -- and I don't think we should in this group -- all of the details. So one of the things that I think we need to look at is what are some of the issues and questions that as part of the collaborative process will provide further detail that comes out of what our recommendation is, which is to fully develop this.

I'd like to flag in particular No. 8. Again, as Barbara noted, we developed these proposals in part based on the responses to the DELFI questionnaire. A key question in terms of the independent third party review is what gets you in the door. And there is three sort of significantly different possibilities of that access point.

One is you need to have your plan doctor, which is what is stated here, another is any licensed health professional, and the third is the patient having gone through the appeal process can get in the door. That is the standard. The last one, the patient

stating the concern and going through the appeal process is what is in place by my understanding in the, I think, 12 states that have this around the country. The language here is the most restrictive possible. It's sort of a doctor in the health plan.

The intent is that this be a binding determination. This wasn't clear in No. 8, but I think it should be. With that -- oh, the other note is to add in the evidence of the intent is that it be a preponderance of medical or scientific evidence.

This isn't intended to be a sort of free for all process. It is to be anchored in what's the correct medical evidence? It is to provide more independent medical review against safety vale, which would be very infrequently used, but it would provide that safety valve.

Comments?

MR. LEE: We've got Michael, Michael, Alain, Clark.

DR. KARPF: I'm sorry I wasn't here through the discussion this morning of what is medical practice because they, in fact, intertwine. I'm not absolutely certain what was decided with this blue ribbon panel. What you said was the blue ribbon panel was approved for defining what's experimental.

CHAIRMAN ENTHOVEN: No. Just working on benefit language only. That's different.

MR. LEE: We're coming up with a common

definition of what does the term "medical necessity" mean, not going through every treatment to say whether that is medically necessary or not.

DR. KARPF: Okay. The issue here is you're going to use expert resources, you're going to try to get evidence-based decisions, is who decides who's an expert and who decides what the evidence is. There's going to be a fair amount of controversy.

So to me this really speaks to the issue of are we going to set up a mechanism for developing some clarity around the issues of medical necessity, appropriateness of care, are we going to set up an organization, a structure that could actually make some of those decisions and develop some precedence that could be used not in one case but in multiple cases recognizing that every case has some nuisances of its own.

And whether this blue ribbon panel -- or whether we're going to set up some kind of board, commission, whatever it is, that deals with questions of medical necessity, appropriateness of care, standard of care, evidence-based medicine, and if we are, who is going to convene this, who is going to set the mandate for it, and who is going to monitor it? And I would propose we do something that be organized as opposed to just say -- go with the capability of calling upon experts in some kind of rampant fashion.

MR. LEE: Michael.

MR. SHAPIRO: I won't repeat arguments. I made a memo to you dated November 17. On the second page, No. 5, that deals with the sole issue of what the trigger is. I objected to the qualification in this that requires that the patient's physician agree before you can appeal it to this external group.

And I'll let Harry Christie explain why that wouldn't have worked for him. Because -- and you get to the issue of a conflict with the medical physician for some reason that disagrees. But I want to point out something I didn't point out here.

If you have a complaint dealing with medical necessity and you don't meet this trigger, that doesn't mean your complaint is not heard. That means it defaults to the Department of Corporations who is now going to make a decision on medical necessity.

So you're going to have second class citizens, you're going to have those folks who got a second opinion from someone saying, "I think you made a mistake. I want someone to look at this issue on medical necessity."

If your doctor agrees with you, you're going to go to the external group. If your doctor made that decision and you disagree and another physician who's licensed agrees with you, you don't get access to that external group. You have to go to the regulator. And I don't think it makes any sense to exclude from the external review body, which is your expert group,

review of decisions simply because your attending physician didn't agree with you.

MR. ZATKIN: Michael, that's not the rem -- the recommendation is not your attending physician. It's when a patient request is supported by a provider in the consumer's health plan, not your treating physician.

MR. SHAPIRO: Medical group.

MR. ZATKIN: It doesn't say "medical group." It says "in the consumer's health plan." I don't know the facts of Harry's case, but I thought that there were physician in groups affiliated with this plan that might have taken a different view of it. I don't know. But this is a broader recommendation than you described. This is supported by a provider and the consumers of health plans, which I presume means its networks.

MR. LEE: I think that's right. This language could be more strict and say their own personal provider or their medical group. This is the health plan as opposed to a licensed provider or no provider.

MR. ZATKIN: It's is broader than --

MR. LEE: We have Alain, then Clark, then Tony.

MR. RODGERS: I just want to clarify. If a person gets a second opinion inside their health plan, you have a right -- the way it's written it

sounds like that person would have a right if that physician says, "I agree with you. Go to this group." But if it's a second opinion outside the health plan, they go to somebody else, they wouldn't have the right?

MR. LEE: As stated here, that's correct. Michael's noting that particular tension, that, with having someone in the plan, as this is stated, they can get access to this binding independent third party review. That other person could still go to the Department of Corporations and say, "I have a complaint."

MR. RODGERS: Could I ask why that separation in your mind was made?

MR. LEE: Really that was sort of more the -- it came in as the midpoint of the DELFI. I personally think that it should be not health professional based. That the other states that have this in place don't provide that threshold and instead have it clear based -- it has to go through the same internal processes so there is a requirement. And people will see what it takes to go through the process and don't just do it willy-nilly.

I think there is threshold or financial threshold questions that may apply to make sure it's not abused but it came stated this way because that was the midpoint of the DELFI.

MR. ZATKIN: Peter, in that regard, the other states refer to a decision denied by the health

plan. That's the way the President's commission phrases the case.

MR. LEE: I believe that is the case.

MS. GRIFFITHS: I want to address that same point. It's a very relevant point. After a two-year legislative debate, the Legislature came up with a proposal which basically said if it's the plan's physician, it has to be one test; if it's not the plan's physician, there's a higher standard.

So what was done was a recognition that he might have cases where it would be appropriate to have a non-plan physician be that the person who supports or even the enrollee themselves be the person who supports getting you over the threshold to get independent review.

But in that case you have to have, you know, some -- the Legislature said two documents from the medical scientific literature that demonstrates that there is -- it's likely to be more beneficial. And they define in detail what the literature is that you have to supply.

MR. LEE: Alain.

CHAIRMAN ENTHOVEN: I'd like to reinforce what Michael said, Michael Karpf, and just to express great concern if we just kind of open this up to any old doctor, I mean, because the problem is very wide raised as I expressed before. And I think of a great article by Fred Mosdeler (phonetic) once that surveyed

evaluations of proposed medical practices.

By the way, most innovations turned out ultimately on controlled trials to be ineffective or harmful. And saying the initial -- here's the initial enthusiasm of the inventor and then here's the first trial which is poorly controlled and then going to -- until they finally get a good randomized controlled trial.

There's just an awful lot of enthusiasm by entrepreneurial doctors that doesn't hold up to evaluation. And I'm very concerned that, if we open this up to -- if the patients can do doctor shopping, we're just asking for huge trouble.

On the other hand, what Michael Karpf is talking about is the need for our developing of an authoritative body within the state. And I thought we were working on words about that someplace. I'm regretting that that's gotten lost. We might be able to come back with something like that.

Or alternatively reference to some of these national technology assessment bodies like ECRI (phonetic), AHCPR and the Blue Cross, Blue Shield, Kaiser Permanente National Technology Assessment Body. Because if we created something like this in California, let's say a joint venture between CMA and the health plans, they wouldn't be able to address all the issues. But these issues do get addressed elsewhere. We need to have some -- tie this into some

authoritative process.

MR. LEE: Clark.

VICE CHAIRMAN KERR: I think ultimately we have to -- the ultimate trigger has to be the consumer themselves. And I think with a suspicion about financial incentives at the health plan and the medical group level, that whole -- it has to happen.

But I think the safeguards that have to be there are that there should be some sort of minimum threshold that needs to take affect so you don't clog the system, but any type of request, I don't know if that's $200, $300, $500, whatever it may be. And I also think there ought to be at least a modest copayment on the part of the consumer themselves so they don't undertake this unless they're serious themselves.

Finally, I'd like to say that I think Alain has a point, that the expert review should not be done by an agent. It should be done by some authoritative expert group so that the consumer actually gets an honest and good opinion as to whether it's necessary or not. But I think, under those circumstance, this is the way it has to be.

MS. DECKER: So you're advocating a dollar threshold of some sort?

VICE CHAIRMAN KERR: Right. I don't know that we should specify it, but I think there should be a threshold. Otherwise, you'll get every single little

thing that comes (inaudible) --

MR. ZATKIN: The President's commission adopted some language on some of these items that I think is instructed. And they referred to a significant threshold or the patient's life or health is jeopardized.

With respect to the standard of review, they say a standard of review that promotes evidence-based decision making and relies on objective evidence. So those are two points that seem to me to be useful.

MR. LEE: Brad.

DR. GILBERT: Peter, I just -- many health plans have contracts with third party organizations to do specifically third party utilization review. I like Steve's suggestion that perhaps part of the threshold results from the seriousness of the case.

Because we have many -- we have a significant number of grievances where there is disagreement about the treatment, but it's really not going to significantly impact the member's health. They need to be resolved. It would result in a very large cost if they were all going through this independent third party review.

So, two questions, Steve's point about the seriousness of the case and, two, if the plan has certain procedures or contracts in place, can that make

a difference in terms of trigger and non-trigger?

There certainly is still the potential for conflict of interest. But in that grievance a non-profit, although supported obviously through (inaudible), health plans or third party review organizations, it obviously depends on their finances, they'll still provide some additional review. How does that enter into this process?

MR. LEE: I'll briefly respond. One, we left as a question in terms of a threshold -- I'm very concerned about a threshold in terms of seriousness. I think that the standard set by the President's commission is a very high standard. In terms of having a dollar threshold that is a not too high threshold I think is quite reasonable. So you don't want anyone to sort of jump into the door. But I'm concerned by what I think is a very high hurdle set by the President's commission.

In terms of the relevant plans in place procedures, one of the things which gets to our next recommendation is that the certified third party reviewers need to be, one, certified. But, also, the placement to them of this issue can't come to the plan because you get repeat business. The concern of repeat business is going to lead to a perception of bias on the part of those entities.

I certainly don't want to discourage plans from using that to reach lower level, faster

resolutions. But I'd be concerned about saying that with them, become binding, and sort of jump over this process.

We have Ron and Michael Karpf.

MR. WILLIAMS: I think this is an extremely important issue for consumers. One of the concerns I have is when I look at 8, 9, 10 and 11 -- these are very detailed recommendations. They're not in the policy level and all kind of mechanics: in network, out of network; in panel, out of panel; is it a physician, isn't it?

And there's a potential to result in substantially poor quality for the consumer at the end of it. I think the standard of review, the preponderance of evidence is an extremely low standard. It would be a scientific or clinical standard. I think the standard of review where it says clearly appropriate or clearly inappropriate, if it's clearly appropriate, 51 percent; or is it 55 percent? You have to be concerned about standard.

I'd like to propose some language for consideration which would essentially say the Legislature and the Governor should direct the states' health plan regulators, whoever they are, to begin a collaborative effort to create an independent third party review process that would provide consumers and health plans with an unbiased, expert-based review of grievances pertaining to medical necessity

appropriateness.

I think these recommendations are just so detailed. I think we need clearly the Governor's and the Legislature's involvement. And we would ask that the regulator begin this collaborative effort to create an independent third party review process. (Inaudible) unbiased, expert review of grievances, medical necessity and appropriateness as opposed to all the detailed recommendations which we'll get through probably about three o'clock.

MR. SHAPIRO: Could I modify that we should just consider these issues as part of that deliberation (inaudible). In other words, the things that are still in here should be part of the consideration.

CHAIRMAN ENTHOVEN: Sure.

DR. DUFFY: I'd like to comment on --

MR. LEE: Dr. Duffy, you're in line now, the fourth down.

Michael Karpf.

DR. KARPF: Actually, I think Ron is taking it to a higher plan. I think that's important. Because I think that what we need to do is develop a process by which we compile, define and standardize approaches and standardize precedence so that we understand where we're going.

We have to be very careful with what we call evidence-based medicine. I think what Professor

Enthoven was pointing out is very true. As an oncologist in training, one of my greatest experiences was to take a look at "faith one" trials, an institution interested in treating a certain disease will come up with some kind of treatment, it looks terrific, you move into a much larger arena where five or six institutions look at it and you have a very different kind of group of patients and all of a sudden it falls apart.

What's evidence-based medicine? The 10 or 15 cases which were the Stage I treatment or -- the Stage I study or the Stage III study which is a national study? It's the Stage III study.

So you need experts looking at what we call evidence-based medicine and you need experts from a variety of different perspectives before you (inaudible). We've got to get it to a very high level. We have to get it to the point where it sets precedence with our standards that are uniform rather than every case on its own tub with everyone bringing in their own set of experts.

MR. LEE: We are at the end of the time that we were supposed to have entirely for this. I would like to call the next three speakers and attempt to do a summary on this.

David.

MR. GRANT: I'll be very brief. We would strenuously object to any recommendation that contained

the language when a patient request is supported by a provider. I think it really flies in the face of good sense to require a physician's prescription to raise a complaint against a physician's practice.

MR. LEE: Diane.

MS. GRIFFITHS: I think Ron hit the nail on the head with this one. In some cases, it appears to be better for the consumer than what the Legislature did in 1663 and other cases. I have real difficultly supporting anything that would require that you have to have a plan physician recommending the treatment.

And also the end sentence in No. 8 which would limit your ability to go to DOC if you go through the independent review process. Those are issues which were debated two years in the Legislature before compromise was struck. And I think we have to have an all-day hearing or several of them here before we came out with this level of detail on this proposal.

MR. LEE: Dr. Duffy.

DR. DUFFY: Just a comment as a practicing physician that Clark here gave. He put his expert as being qualified in the field. That is very important because many times you're reviewed not by anybody that's got any confidence. You want an expert in the same field or a comparable field for this orthopedic's surgery. If you're going to be reviewed, you have to have that. That's very critical.

CHAIRMAN ENTHOVEN: Could I have Ron's

language?

MR. LEE: I'll sit down with Ron. I'll be happy to -- what I heard is to keep the issues raised here as the issues that need to be considered and to note that.

The one concern I have with Ron's language is that, again, the collaborative process. I absolutely agree with the collaborative process. But, again, I think there needs to be a charge to come back with a result. It's important for this Task Force to say there needs to be independent third party review.

And the health regulator should develop the process by which a full proposal would be, you know, developed through a collaborative process to come back in a relatively sort period of time. And I would say it would be two years. It would be very offset. I think it should be within a year.

My concern is that we shouldn't say to the State of California that what we're doing is thinking about this. We're saying this is needed, these particular elements need to be worked out. And if that's a friendly amendment to Ron's friendly amendment, we'll work on the introductory language.

DR. KARPF: Peter, what I'm concerned about is we have this (inaudible) -- that's not going to work. I think that, as we go through some of the recommendations we've made as we look at this issue, there has to be some approach that integrates the

suggestions that we're making and the actions we're trying to bring together.

So whatever body gets organized probably should be tied, this new entity, whatever it may be, whatever we want to call it, that entity should have the responsibility of chartering it, monitoring it and reviewing it.

DR. ROMERO: If I could piggyback on that. I meant to mention this before. I have been assuming that any time a blue ribbon panel or its equivalent like this are suggested that OSO or whatever the final regulator is called would be the convener of that organization. And I would like it flagged specifically if the Task Force does not wish that because otherwise that will be my default assumption.

DR. KARPF: I would assume as part of wrapping this process up in the last couple of days that we have an opportunity to take a look at all of these bodies that we've tried to charter and understand how they fit in to integrity rather than having a bunch of things out there floating in space.

MS. GRIFFITHS: Phil, I have a question on the point you just made. When you say the convener, do you mean that -- whatever that entity is we picked? The particular participants in any of those groups? I think that's a much more controversial issue, and that should be discussed and probably will be discussed through the next draft.

DR. ROMERO: I'd certainly say that their discretion about who they pick should be constrained by the recommendations to the Task Force and any higher authority like the Governor or the Legislature. But beyond that I haven't given it much thought.

MR. ZATKIN: Phil, were you saying all the blue ribbon panels met that test or are you saying all of the recommendations relating to convening folks? Because we had some private sector recommendation.

DR. ROMERO: I meant only those in which -- some sort of blue ribbon panel in which there was public participation.

MR. ZAREMBERG: I would personally like to see a list of every entity that we recommended so that we have some understanding of where they fit. We have to make sure there's some consistency.

DR. ROMERO: Fair enough.

MR. LEE: We might also in doing that recommend that these three panels be one.

DR. ROMERO: Right.

MR. LEE: I'd like to flat, if I could, the one thing that is not in this is Michael's second notion of -- an actual process by which the standards that are determined to be authoritative are developed. That is not here. This is a separate issue about having an expert body decide individual issues.

And, Michael, if you now want to bring that up, you need to do so. It's not a part of this

right here. I'm just flagging that.

DR. KARPF: I would certainly like to see that included. I think if you're going to have experts decide, it would be nice to make sure they have a reasonable yardstick by which they are deciding. We have to get some of the arbitrariness out of it.

CHAIRMAN ENTHOVEN: Michael and I would be happy to work on something and come back to plug in there.

MR. CHRISTIE: One last comment, on the subject of independent third party review, I vote for this being absolutely crucial. What I have found in my experience was that, when the plans process were not open to outside review, the administrative law judge found that there was a very perfunctory review done by the plan.

And if we had had the benefit of a third party independent reviewer, we could have probably avoided all the hassle that we went through. So I totally support the idea of an independent third party. And I don't think it should be only instituted once you go into the full grievance process because that in and of itself could take an enrollee anywhere from 120 days to 12 months, possibly longer.

MR. LEE: That comment goes to one of the other comments that I got from a number of people which is that the timing with which one can access this isn't spelled out here. It's one that we should flag and we

should consider. Even if you're in process for 60 days, then you should be able to get (inaudible). But we can add that to the list of issues to be considered in the development.

If I could move us ever so quickly to twelve, I would suggest to move to -- arbitration -- what I noted is that the request will be carried, this discussion and vote, to the December meeting since Marty Gallegos is not here.

Is that acceptable to the --

MS. GRIFFITHS: Marty asked me to present his recommendations, and I'm more than happy to let him do that.

MR. LEE: Given the time, I think we'll probably have more time in December than we will the rest of the day given everything else we need to discuss today. Is that all right with the Task Force?

So those will be incorporated in the paper for discussion, recognizing that we have not voted on them as they stand, but we'll be able to vote on them then.

CHAIRMAN ENTHOVEN: I read them, and I thought they were exceptional except for one which could -- could we just wait?

MR. ZAREMBERG: Did Peter say he was going to incorporate all of Marty's suggestions in your paper?

MR. LEE: Yes.

MR. ZAREMBERG: So we have to vote to take them out?

MR. LEE: Right. Whichever way, we'll vote on them all. If you want to have them as a separate sheet of paper as opposed to being here, given that we have so much trouble with separate sheets of paper floating around, my suggestion was really -- was not saying to treat them as having been straw polled. If you want to put a flag saying no straw poll yet taken, that will be fine. Let's try to not have things floating around.

MR. WILLIAMS: I'd like to have a vote to put them in as opposed to take them out.

MS. GRIFFITHS: Could we just put them there and say that it would require 16 votes to keep them in?

MR. LEE: 16 votes to keep in. Great. Okay.

Number 12 on assessment, move with no objections.

The last issue, if I could, is the additional issue ERISA. The main issue, we do have an act on one ERISA-related recommendation already which is to at the very least encourage employers to by contract adopt these same standards.

Michael submitted further recommendations which you'll find under November 13, which is to encourage the Department of Labor to implement the same

standard we talked about here. The goal, again, cutting across here is to have common standard regardless of payer or plan type. We certainly have flagged that ERISA disabled that goal.

MS. DECKER: It would probably be helpful if you refer to page 15 of the document and you go back to the -- it's the end page of this section. And here we try to outline the issues around ERISA. Again, it's -- as an employer has ERISA plans, obviously I feel that it has some value.

But we wanted to get a feeling from the Task Force about what kind of approach you'd recommend we take. And in the last paragraph it has I think from least intrusive to most strong a series of recommendations. So A, make no reference to ERISA and, continuing, B is what's already incorporated earlier in the paper.

Comments about ERISA. Michael?

MR. SHAPIRO: Just a brief one. On your table is a memo, No. 13. It just suggests the focus on working with the Department of Labor to coordinate the state and labors programs to the extent they come in under law, to be added to the earlier one about voluntarily compliance.

The only distinction I would make is things you could do without amending ERISA are voluntarily compliance, you work for the Department of Labor, assuming the law has not been changed, versus

putting all your eggs in, go to Congress, amend ERISA. I'm not against those. But the most practical ones are work with the industry on a voluntary basis, work for the Department of Labor on a voluntary basis to coordinate because (inaudible). So I just emphasize the one that's already been cited, voluntary compliance, and this one is things you can do without changing the law.

DR. ROMERO: Michael, just to track, your recommendation in November 13 looks to me to be summarized as C in the paper. Is that accurate?

MR. SHAPIRO: I just wanted to put it with the earlier one which does not require changing ERISA.

DR. ROMERO: I just wanted the translation is all.

MR. LEE: Michael has done a clear statement of what is C on page 15. But his location is moving up next to the other recommendation of employers.

MS. DECKER: John Ramey.

CHAIRMAN ENTHOVEN: Let me warn everybody that the restaurant is closing at 2:00. Why don't we take a straw poll to see how many people favor --

MR. RAMEY: This will take maybe less than a minute. I am struck as we go through the list of recommendations. Although I object to none, it seems to me that, in using the language that Ron used

at the end of the day, we are adding significant cost to this system.

The ERISA folks always look around and pretty easily agree to these things because they know the costs really get out of hand. They can always run and shield themselves with ERISA from increased costs if they have to.

Who's left? Individuals and small employers in the state to pay the cost. When I talk to uninsured folks, what they tell me is they choose (inaudible) to have some coverage even if it's as imperfect as the coverage that they might have to get under our existing system and existing rules.

So I think that, even though last week we exempted the staff from the necessity of doing any cost estimates associated with any of our recommendations, it sure as hell is something we ought to keep in mind from time to time.

MR. LEE: J.D.

DR. NORTHWAY: I'll pass.

MR. LEE: Any objections to Michael's proposed language for C?

Without objection --

MR. WILLIAMS: One clarifying question. Is the object of C to make all of the relevant Task Force recommendations, to make the proper request that all relevant Task Force recommendations apply to ERISA exempt plans or subject to dispute resolution?

MR. LEE: When I say C, I'm saying that the Shapiro C which specifically notes to dispute resolution.

MR. SHAPIRO: The reason I did it that way is the DOL solicitation actually talks about the process (inaudible). That's the solicitation, state -- show me what you do to deal with disputes and timing process. So I'm not opposed to broader, but that's all they solicited. That's all that we're doing here.

MR. LEE: Without objection.

MS. DECKER: So the tone of the room is to do B and C is what I'm hearing.

MR. LEE: Right.

CHAIRMAN ENTHOVEN: Yes.

(Lunch.)

CHAIRMAN ENTHOVEN: Will the members please take their seats. We're going to begin with representatives of the general public. We'll begin with Maureen O'Haren followed by Beth Capell followed by Clare Smith on the dispute resolution. To my regret, I need to rigorously enforce the three-minute rule. I feel badly about that. I have to do this.

MS. O'HAREN: Thank you, Mr. Chairman. In fact, I don't think I have three minutes. I think a lot of the issues were dealt with in the discussion.

I have two comments: One I made on an earlier paper that existing law should be stated wherever it's relevant. And I think that that would

help the Legislature and any other reader of this report if you would state, for example, as Mr. Shapiro pointed out, the requirements of SB 689 and the 30 days that apply to health care service plans will have a 5-day expedited review.

And secondly, I would reiterate our concern about the public reports section. I know that Peter tried to modify it a little bit. I think that the data elements that are specified there would call for a very detailed, very lengthy, very costly from a plan standpoint report. And I think that it would be better if the data elements were not specified and it would be left to the regulator to determine how best to provide information to the public on situation grievances in the plans. Thank you.

CHAIRMAN ENTHOVEN: Thank you very much.

Beth Capell.

MS. CAPELL: No, thank you. My comments were already covered.

CHAIRMAN ENTHOVEN: Clare Smith from California Health Insurance Counseling and Advocacy Program, the high cap program.

MS. SMITH: Good afternoon and thank you for the opportunity to speak to the chairman as well as members of the Task Force. It's encouraging to hear reference to the Health Insurance Counseling and Advocacy Program and our services.

I am here representing 24 programs

statewide and want to underscore the importance and the reality that our projects are, as we speak, providing the type of information that is described in your -- in the external consumer assistance section of your paper:

Developing and distributing educational material, providing referrals to resources and providing long term -- and I do want to say long-term counseling services to Medicare beneficiaries and their family members and that includes certainly people 65 years and older and younger Medicare beneficiaries.

We also provide direct assistance and guidance to problem resolution. I'm here today formally to request that we have the opportunity to work in the collaborative working group that has been referenced in the paper on looking at this particular issue.

We have experience in dealing with the current patchwork of regulatory processes provided to us through the federal group, the Health Care Finance Administration as well as the state Department of Corporation as well as the various medical groups at the local level and the corporate Health Maintenance Organizations themselves.

In any case, again, we look forward to working as part of the group that would be established to look closely at these issues. Thank you for this opportunity.

CHAIRMAN ENTHOVEN: Thank you very much

for appearing before us. Now we will move to consumer information, communication and involvement. We're coming up to 2:30, and this meeting will end at 5:00. So it's important that we move rather quickly.

I do think that the forthcoming one is less complex and less controversial. I'd like to commend and thank Jeanne and Ellen. We'll start with Jeanne's part. So Jeanne's focus is on consumer information. Let's go.

MS. FINBERG: You all had a chance, I hope, to take a look at the paper. This is one of those papers that has been through many drafts, many revisions. We've gotten contributions and suggestions from all types of sources, from industry, from consumers, from medical associations, et cetera.

And it represents a compromise. It doesn't go as far as some of us might like. It goes farther than others would like. But I really feel like it's a strong paper and staff particularly worked very hard to accommodate various requests and needs.

There was a mistake in disseminating it in terms of the underlying portions. Because this is the first time it's been out for review to the members, you can ignore those. They weren't really meant to be more or less important, and they aren't revisions that members have made. It was kind of a clerical issue. So I hope that doesn't confuse you.

In the interest of time, we'll go

straight to the recommendations, and I'll kind of walk you through the consumer information part and then Ellen will take over and talk about the consumer involvement part.

I guess following the success of the last group, it sounds like what we should probably do is move forward unless we have concerns, criticisms or suggestions. And so I assume we'll generally do that mode.

We do welcome additional improvements or language tinkering. You can give things that are minor to us later, things that you think would make a pivotal difference in the discussion should probably be raised now so that we can straw poll more controversial things.

So looking at page 3 I guess it is, looking at the beginning of the recommendations, Recommendation No. 1, this is in response to a lot of concerns that consumers don't understand what managed care is. People don't know if they're an HMO or a PPO that we should have a source of information that really describes managed care and how it works in California. We know that there is various other private and public pieces or partial pieces that are out there.

But we wanted something that is comprehensive, only about California, that was consumer friendly. So we're asking that the state agency announce the DOC, it could be whatever our new agency

is, issue an RFP to do it. They can do it themselves or they could have some other entity produce this. We think it should be done annually and it should describe what's happening be tested and evaluated.

Bruce.

DR. SPURLOCK: My question really goes to the potential cost of something like this. I'm sure you don't have exactly -- is there any idea of the cost of the RFP and then the cost of the dissemination program? We have 22 million Californians or 18 million Californians. It adds up very quickly. And the cost -- it would just be interesting, the tradeoffs, from a cost benefit standpoint.

MS. FINBERG: No. I'm afraid we don't have information on cost. Yes, I'm sure it does cost something, but we don't have information on that.

Yes, Rodney.

DR. ARMSTEAD: Just a real quick question. Again, this is a really helpful clarification. How would you envision this being accomplished as far as the production and a simple enough reading level and sufficient formats and languages to all customers? And I know that's -- it's customers relative to the plan.

I think that there are ways they're accomplishing that now. I'm just trying to envision and kind of tying into what Bruce's point is which is is this going to be for those plans that are doing it

well, they're going to continue to do it well, are you trying to envision some type of a -- am I envisioning something that will be more applicable to streamlining the types of products that are information based, that are more comprehensive, if you will, or you know -- I guess what I'm trying to get at is is there going to be a lot of the change? Do you envision there being a lot of change from what some plans are currently doing? For example, we do publication in six languages now.

MS. FINBERG: Let me clarify. This is not going to be something that's done by the plans themselves. It will be done by the Department of Corporations or whoever they hire to do the job. It will be generic. It's supposed to describe what's happening in all the plans in the state and it would describe the types of plans.

In terms of language, it's pretty clear we're going to need a Spanish version. How many other versions are appropriate, necessary? The state agency will have to determine that and put that into the Request for Proposal. So I don't think we need to determine that level of detail.

CHAIRMAN ENTHOVEN: Think of a booklet like the DMV's booklet on the driving rules or something like that.

MS. FINBERG: Right. That's a good example.

Michael.

MR. SHAPIRO: Just two comments. The reference to the term "a booklet on the managed care systems" is very broad. The reason I ask is will that have a simplified explanation of here's your plan, the regulator might help you or is it external resources? Is it just talking about the industry or is it somehow helpful?

Number 2, in terms of minimizing the cost of distribution, in other agencies that I've worked with where the state is imposing plans often, we distributed -- it's a state document, but we distribute it with the regulated industry, something that's available there to -- it's an enormous mailing process. The costs here could be potentially enormous. We've had in the utility field plans where there's an insert saying it's available, plans -- it's at your doctor's office. Is there any way of doing it but minimizing the cost of distribution?

MS. FINBERG: That raises two important points. In terms of the managed care system, I think we didn't mean it to be narrow. When I look at it now, I think it might even leave out some of the important health insurance products. It probably should say "health care system" instead of just "managed care" so it describes what a PPO and what an indemnity plan is and who those people would go to.

In terms of distribution, I think that it could certainly be available from the state, but

probably once it's produced and it is available, the plans could give it out with their materials.

MR. WILLIAMS: This is a very important issue. I know all the health plans struggle with how do you get the consumers to read the materials provided that are provided already to them? I guess there would be a couple of questions I have.

One is who pays for the production of it? The second one is how would it be envisioned to differ from the materials that health plans produce today which are designed to explain how a specific plan works and how the generic models work and the kinds of materials that their regulators would approve as education and orientation material?

MS. FINBERG: We didn't address a cost at all. So I don't have any answer to that. In terms of how it's different, we felt it was important to have something that could be viewed as unbiased and comprehensive.

So some of the plan -- market plan materials are, you know, very good but they focus on a particular plan. Some of them particularly promote their product. This would be something more neutral and would cover all types of plans and tell consumers where they can go to for help.

CHAIRMAN ENTHOVEN: We might be able to get foundation support from the Wellness Foundation.

MS. FINBERG: Steve.

MR. ZATKIN: Just that the plans differ significantly one from another. So I think it would be hard to provide a booklet that accurately described very much about the plans. You could do a booklet that talked about health coverage in general and where one can get help if one has questions or has problems.

But I would be concerned about the booklet attempting to describe a whole lot about the plan because there is such a variation. I'm not against the idea. I'm just making that point.

MS. FINBERG: I think one thing that would be really helpful for consumers is to know what the types of preachers are out there and if you gave that example of "the following plans in the state use the staff model as an HMO" and had a list and, for example, the IPA medical group models and you had a list, I think that would be very helpful. It doesn't have to give the details about a particular plan.

CHAIRMAN ENTHOVEN: An awful lot of people in this state don't even understand that, when they were put into an HMO, that this coverage was only good for the participating providers, a lot of basic things like that never got explained that are fairly generic.

Clark Kerr.

VICE CHAIRMAN KERR: Two things on distribution. One is obviously Internet, which is fairly inexpensive; and the other is if it were a news

release, it could be made exciting. That might get to a lot of people in the newspapers that wouldn't cost a lot of money. In other words, most people get newspapers so that might save. That might be an interesting thing.

The other one is to suggest that, if you can do it in cartoons in explaining things, then I think your readership would be very high as opposed to a lot of (inaudible).

CHAIRMAN ENTHOVEN: Nancy.

MS. FARBER: Getting people to read their health insurance plans and what they cover and what they don't cover is a really serious problem. We have a health insurance counseling service in the Washington township. The district has a special responsibility to the residents of the district, and this is something we provide free of charge.

And our experience is we see residents in the district appearing there two times. One is at open enrollment when they're offered multiple choices and they don't know how to make a choice and the second time is when they run into trouble. And other than that, I doubt that you're going to ever get people to read their health insurance plans. I despair that that would ever happen.

I know that there's a requirement in the State of California for all nonprofits to report to the Office of Statewide Health Planning and Development

what they do for their communities to establish their nonprofit -- retain their nonprofit identity, not establish it, but to establish it at least annually that they're doing something.

I'm not sure that hospitals are the best place to do that but they are a facility in the community and it's working well in Washington township. And I don't know if I would advocate this for every hospital because not every hospital in California is nonprofit but that would be a good way to fulfill that community service obligation. And it would be very helpful to the residents in that community.

Something that -- we started this service about a year and a half, two years ago, and it's a very, very busy service. People have access to it either by phone or in person. And it's actually when they come in in person that it's the most effective. They won't sit down and read a health plan. They need somebody to walk them through it who is not selling them insurance, and I think it works best that way.

CHAIRMAN ENTHOVEN: Great. Without objection, could we accept that idea and proceed to the next? And people are encouraged to send in positive contributions about how to make this a better idea, somehow to get the people to understand that there is some basic things about their health plans.

MS. FARBER: They don't get worried about it until it's too late. When they have a problem, it's

a dollar short.

CHAIRMAN ENTHOVEN: I think your idea is wonderful, that is, when they come in at the beginning, to hand them out and say, "Please read this."

MS. FARBER: If you could get OSHPD to encourage hospitals to meet at least a portion of their community service obligation as a nonprofit by providing such a service, I think that that may be a beginning point.

CHAIRMAN ENTHOVEN: The second point, Jeanne, is this just about the same as what we said in the standardization paper?

MS. FINBERG: Are you talking about Recommendation No. 2 now?

CHAIRMAN ENTHOVEN: No. 2, yes.

MS. FINBERG: I think it is similar. It goes a little bit further. I think we'll probably have to take another look at those and make sure they conform with each other. This would be to have a standardized evidence of coverage and to have an annual standard product description.

And we gave some examples of things that we felt were important to include in that and some of which I think we adopted earlier, the paper that Al mentioned and there is also the drug formulary decisions. I think we already adopted a recommendation to disseminate that.

Also, the grievance procedure, exit

polling information which would indicate numbers of people that disenrolled and their primary reason for disenrolling and a description of the referral and authorization process. That's an area of high concern and interest to consumers.

So we thought it was very important that that be easily found and described in a standardized fashion and the process with which medical decisions are made. And this information would be available to consumers. And, actually, they already put the Internet down. So we have to add it to the other one.

CHAIRMAN ENTHOVEN: Great. Comments? Discussion?

We will work to conform it with the other paper.

MS. FINBERG: Number 3 is that plans would submit to the state agency approximately ten major health conditions or illnesses that require referrals to specialty centers or centers of excellence. And that then data would be reported annually for the year including for the condition or procedure where the patient received care and how many of the procedures were referred. That gives the consumer an idea of what happens when I really get sick, where can I go or is, you know, the plan's list exclusive.

VICE CHAIRMAN KERR: Where possible, you want to also include risk-adjusted outcomes as that --

MS. FINBERG: That sounds like a friendly amendment.

MR. LEE: Another friendly amendment. I think it's implied that when you say obviously none of this would impinge upon the confidentiality of any individual patient record, this is aggregate data, just to make that clear. I think it's clearly in the intent but if you would just spell it out that this is to aggregate.

CHAIRMAN ENTHOVEN: It's just to say if I might need heart surgery, where have you been sending people and how many have they been doing lately?

MR. LEE: Right.

MS. FINBERG: Okay. So retaining patient confidentiality.

CHAIRMAN ENTHOVEN: Ron.

MR. WILLIAMS: One thing I'm not clear on is this is where the health plan is sending the person or where the medical group is choosing to refer for that particular condition? I guess part of the thing that I'm confused about is the -- if you're in a network or IPA model, the actual judgment about what network in the hospital of the 450 hospitals in the network that a member is going to is the judgment of the treating physician not a judgment of the health plan.

CHAIRMAN ENTHOVEN: One thing about making this historical is just to say what happened

last year? And you may have to list we sent people to 15 different hospitals for heart surgery and these were their volumes. So it's by health plan.

MS. FINBERG: Would it be better to make the reporting requirement applied to the group or IPA?

MR. WILLIAMS: I guess that would be my recommendation, that it ought to be the health plan and the IPA that collects and disseminates this information. I think what we know from the point of view of the health plan is how many patients there were in a given hospital. We don't necessarily know exactly what the originating condition was that put them there, it may have been a heart condition or some other condition resulting in a heart condition.

DR. KARPF: You do have to put it into the process, Ron, because your organization does say to some IPAs, some providers, these are the Blue Cross certified plans is where we want you to send them as opposed to send them anyplace you can get it.

MR. WILLIAMS: I think the point is that as a broad network model as opposed to a narrow network model we have relationships with a broad number of hospitals so that before any specialty service they can pick one or two centers in a given geography. If you're in a fairly narrow model, there really is only one place that a health plan might be likely to refer.

CHAIRMAN ENTHOVEN: Peter.

MR. LEE: I think the friendly amendment

to this would be that health plans and medical groups -- unfortunately, I don't think it's an "or" -- that medical groups need to have a certain size report. We tried to address that, maybe not very articulately, but in dispute resolution it can't be a medical group of two people aggregating this data.

It's important for consumers to know both levels of choice. They may be making their choice at the plan level or at the medical group level. There may be some medical groups that are in Blue Cross that they always send to one center of excellence that ain't so excellent as opposed to others that send very excellent ones, both of which are within your allowed possible network.

MS. FINBERG: So we can make it plans and medical groups or IPAs above a certain size?

MR. LEE: Appropriate threshold.

CHAIRMAN ENTHOVEN: Let's be working on the concept of it.

MR. ZATKIN: "Where" I understand. That's the hospitals. From whom meaning the specific physician?

CHAIRMAN ENTHOVEN: No. The --

MR. ZATKIN: From whom means --

MS. FINBERG: From which.

CHAIRMAN ENTHOVEN: The referring entity from which.

Duffy.

DR. DUFFY: Centers of excellence is a very controversial term in orthopedics at the present time sufficiently controversial that the Mayo Clinic refused to participate in it considering the center of excellence being the cheapest place that the -- Medicare can bargain with. So our academy is basically pulled out of that whole idea center of excellence.

CHAIRMAN ENTHOVEN: Should we strike that and just say "specialty centers"?

DR. DUFFY: "Specialty centers" would be fine. "Centers of excellence" may sound different. Yes.

CHAIRMAN ENTHOVEN: You're right. It has unfortunately taken on a political -- Bruce.

DR. SPURLOCK: Thank you. I actually have discussed this issue on a couple of areas before. I think after listening to what everybody is talking about, having risk adjustments, having information at the treatment level or the provider level, I think really the spirit of this is to get back to the quality information group, what it's trying to accomplish.

I don't think, without having it at that level, that we're really going to be able to disseminate this appropriately. It's not just the DOC that needs to know this. Consumers need to know this. We need to have valid, not self-reported, I think self-report is struck with bias. We need to have valid and reliable information on all of these things that

are collected externally to the process of people that are actually delivering the care.

They need to be risk adjusted, they need to have some connection with the kind of outcomes that we think they're going to have. So I think that is addressed in the new quality of information paper. And we want to include the DOC as recipients of that information. I'm all for it. But I really think that this is the spirit, the way it's currently constructed.

CHAIRMAN ENTHOVEN: This is for consumers. One thing is OSHPD could do it if they were allowed to collect the health plan and the referring medical group or IPA on the hospital discharge abstract.

DR. SPURLOCK: I think that's a partially correct statement. I think the risk adjustment part is not necessarily accurate on that statement.

CHAIRMAN ENTHOVEN: I agree. But I mean the other question. Just where do you send them, you know?

DR. SPURLOCK: I don't know. I'm just wondering if it were better structured under the new quality of information in which we actually include these concepts. I'm not sure it belongs in here for this reason.

CHAIRMAN ENTHOVEN: Okay. Conceptually the way we try to draw the line is to say there's an

awful lot of information that exists. There's some that you can pull up on the PBGH website. And the big problem that Jeanne was focusing on was with all that stuff that exists there, how do we organize and package it and transport it to consumers in usable form?

While Clark was focusing on information that does not now exist, how can data systems make the -- I realize that's a fuzzy interface and it's imperfect, but that's kind of what we were trying to do.

DR. WERDEGAR: I was going to speak for OSHPD on this. I think that Bruce has captured the spirit of this. Without being as specific as this is -- and I worry that it's not risk adjusted and you have a list -- that either the blue ribbon committee that we've been talking about that's going to work on standards and what is the best care or somewhere in the quality paper -- I don't remember all the elements of it -- this reporting to go on and allow it to be properly studied and risk adjusted, I worry about a list or outcomes that haven't been done.

CHAIRMAN ENTHOVEN: This is not outcomes until we get, you know, authentic risk adjustment measures of outcomes. It was just to say where you send the people and what are their volumes? If I'm going to need a heart surgery, are you going to send me to South San Jose Medical Center or are you going to send me to Mercy? Where do you send --

DR. WERDEGAR: The interest in this is strictly in the volumes?

CHAIRMAN ENTHOVEN: Yes. Unless and until we get valid risk adjusted measures of outcomes.

Yes, Barbara.

MS. DECKER: A minor point, I think from the way I read the item, it says that the plan or medical group or other entity is reporting this and then they're reporting -- like they go to Center X, they're saying how many heart bypasses Center X did. Is it reasonable that the medical group or the IPA actually can report how many the receiving organizations get -- I'm just thinking about sources of information.

CHAIRMAN ENTHOVEN: You would like to think they do that.

MS. DECKER: They might not know it for the current year. Because they might be doing it based on the year before.

CHAIRMAN ENTHOVEN: That's why we said the past year. And if they don't know it, then they'll define for them, put a little note, you know, "The Palo Alto Clinic does not know how many heart transplants" --

MS. DECKER: You're reporting I sent 10 there for '99 and they're saying, "And we know they did about" -- in '98. So there's a year distinction. Okay. Got it.

MS. FINBERG: All of these suggestions about how to improve this information are really good ones. That I don't generally prefer self-reported information, but I am patient to wait until all of the requirements are made. So I think the suggestions on improvements in the other areas are a good idea. This is rough data that a consumer can look at to know is it a theoretical possibility that I get to go to Stanford? Or did anybody in the plan ever get sent there last year? That's the kind of level we're talking about.

CHAIRMAN ENTHOVEN: Could we say without objection the concept is -- we'll work on these -- incorporating these ideas. Then No. 4.

MS. FINBERG: Upon request by an enrollee, all plans, medical groups -- and we should insert IPAs here -- should be required to provide copies of any written treatment guidelines or authorization criteria.

CHAIRMAN ENTHOVEN: Discussion.

MR. ZATKIN: Would that be related to the enrollee's condition or anything?

MS. FINBERG: We didn't limit it that way because we were concerned about that by itself becoming a subject of dispute. But the idea is that it's for people that are concerned about things happening to them or to their family members that they could get written guidelines that are being used by the plan or the medical group.

MR. ZATKIN: I guess I would argue that it ought to be related to the enrollee's condition.

MS. FINBERG: Or a family member?

MR. ZATKIN: That's fine.

MS. FINBERG: What about anticipating a condition, what about worry, about what happens if I have a heart attack? That's the problem with it being related to my condition. Because if I'm choosing a health plan, I might not have that condition yet, but I might know that my mom had it and my grandmother had it so I want to be on the lookout for it.

MR. ZATKIN: I guess the question is the guidelines and the books. So where's the reasonable limit?

MR. ZAREMBERG: From a point of practicality, many of these guidelines are not going to be in text. They're going to be in schematics or flow sheets. They're going to be difficult to understand for some of our physicians let alone for some of the lay individuals.

And so this may be a very nice idea. But if it's not put into a framework where it's readily understood, I'm not sure how far it will get.

MS. FINBERG: Yes. I think that is an issue. We were careful not to require production of anything for the obvious reasons of cost, et cetera. So that's why we just stay away from that to make it understandable. I feel like at least I can get that

information. If they need to bring it to someone else to interpret, then they're going to have to do that. They can ask their own physicians questions about it.

MR. SHAPIRO: Jeanne, in the spirit of Steve's concern, maybe you can compromise by having requests for guidelines and authorization criteria by a condition. You don't have to have a condition to request it. But that way you don't get the book if you don't it. Whereas Consumers Union can get the book, who wants to compare plans, individuals. You can at least ask them are you worried about asthma? Are you worried about coronary issues? So you can limit -- but if a person wants it all, they can get it all. I think there's a point that you might be provided the information that's not relevant to the consumer. So I'd ask you to think about that.

CHAIRMAN ENTHOVEN: A little bit of a problem with this and with the earlier information about being available on request free of charge, I almost wonder whether a modest fee just to get people to think twice would be appropriate to help defray the costs.

MS. FINBERG: The reason we put that in is we had problems with people trying to get information from the Department of Corporations to get, for example, a copy of a survey from a plan and it turns out it was $150. So that's why we put that in. I think a nominal charge would be fine. The problem is

it should be something that's accessible. So maybe we can put in a nominal charge.

CHAIRMAN ENTHOVEN: Just like if you charge $2.00, people will think twice and not waste it. If it's free, they're going to --

MS. FINBERG: Right.

CHAIRMAN ENTHOVEN: And of course, some of this going on the Internet could help. Of course I agree with you, the DOC has been a disaster from the point of the agency being able to get information out of them. And when that gets on the Internet, that would be helpful.

MS. FINBERG: The DOC has a web page.

CHAIRMAN ENTHOVEN: Is --

DR. KARPF: Just a point of clarification, I was pointing out to Ron that he should probably point out that plans don't have critical pathways. Groups don't necessarily have critical pathways either. Hospitals often have critical pathways or medical staffs with hospitals will have critical pathways.

So if you really want to do this, you have to know what door to knock on. You go to a physician who is going to -- who you're going to be seeing, the critical pathway may reside at the hospital where he's privileged to new procedures as opposed to his office.

MS. FINBERG: So should we add hospitals

to that are you saying?

MR. LEE: Let the record reflect that Karpf has proposed that hospitals should also be added.

(Laughter.)

DR. KARPF: I'm saying we should figure out some language so that there is some access to it.

MR. LEE: A point about the enrollee is that I'm really very concerned about it being too limited. I don't think the intent is to conclude a person who is not a current enrollee or a consumer group from getting access. I think that available at a nominal cost, whether it's the cost of copying as a description of nominal so nominal doesn't become $25.00 as if that's not a lot which it could be. But for copying costs.

CHAIRMAN ENTHOVEN: As opposed to mailing, handling and copying.

MR. LEE: It's certainly reasonable. I think it needs to be available for enrollees or to the public in some way to see that it's not willy-nilly and have plans absorb a lot of cost. But this is one of the things that -- I want the Alzheimer's Association to be looking at a number of guidelines saying, "Hey, this is off the wall," and not have them precluded from getting that because they are not a current enrollee.

MS. FINBERG: So an enrollee, consumer group, or organization?

MR. LEE: Member of the public.

MS. FINBERG: Member of the public?

Okay.

CHAIRMAN ENTHOVEN: Because everyone is a potential member of Plan X. I'm considering joining Plan X next year, and I want to know how they treat my -- okay. Is that conceptually -- again, suggestions on the wording. These have been very helpful.

Could we go on to 5? This is something that's been pioneered by the HIPC.

Is John Ramey here?

MR. RAMEY: Yes.

CHAIRMAN ENTHOVEN: I'm glad you're here.

It's a great contribution of John's.

Jeanne, do you want to take it from there? Just so nobody thinks it's never been done before.

MS. FINBERG: Okay. This idea is to have a comprehensive directory that contains all the critical information within the plan or the group level that would indicate who the providers are and it would be very current. And if it was on the Internet, of course it could be instantly updated as the information becomes available to that entity.

But it should also be provided once in a while in hard copy for those consumers that don't have computers or access to the Internet. We had some specifics down here about things that we thought it was important to include, particularly who's on the

network, what specialists are available to that particular person within the plan or the medical group.

CHAIRMAN ENTHOVEN: Go ahead.

DR. SPURLOCK: Thank you, Mr. Chairman.

I totally endorse this concept of a super directory. The Health Data Summit is actually tackling this issue. It's a humongous issue. It's just a great directory. For one (inaudible), to maintain it costs a lot of money. And as I read this, the agency charges (inaudible). And that's been one of our questions at the data assembly. If we can accomplish the cost of doing that, I think that there are a lot of people that would like to make this happen right away.

MS. FINBERG: See, the agency that is in charge of overseeing it has to have this information. I mean, they are legally required to be assuring adequacy of the network and the limitations, et cetera. So that, although they might not have it readily available in an organized fashion, it is their job to have this information because they're already doing it.

CHAIRMAN ENTHOVEN: An entrepreneur is creating a new company called Analytics. He's telling me that he's getting this information on line from many of the health plans now and putting it out on line to subscribers. So the Internet is a marvelous technology for some people. It would really be very useful.

Other comments?

John Ramey, did you have -- do you want

to take credit for your accomplishments?

MR. RAMEY: No. The longer the discussion goes, the less credit I want to take.

CHAIRMAN ENTHOVEN: Barbara Decker.

MS. DECKER: My original thinking when I read this was that the consumer side of it, which I'm very much in favor of and have supported by sending a staff member to a meeting I think today to work on the super directly for PBGH, is that if I want to see where Dr. Smith is, I can look at Dr. Smith and say (inaudible), et cetera.

I think that's different than what the DOC or the super regulatory agency needs. They're looking at it from a different point of view. I'm looking for a cross reference, which plan could I be in and attempt to get to this specialist, et cetera.

So I do think there are two different things that we're talking about here. And assuming that the regulating agency, whatever that may be, will need it if it's cross-referencing, I'm not sure that's a valid hope.

The other item I mentioned is that I think in the second paragraph, if this is going to work ideally the way I'd like it to work, you need to know what medical group or IPA a specialist is in so you know how to get to a primary care physician to get referred to that specialist.

MS. FINBERG: We meant to be saying that,

so we're going to add language a little bit to tighten it up.

CHAIRMAN ENTHOVEN: John?

MR. RAMEY: Like everything else, not everything is quite as simple as it seems. It isn't just a matter of slapping this on the Internet. The problem is that most plans keep this in their own unique electronic data processing way.

Somehow they're on word processing software, some of them have it on -- well, all kinds of different software is the way that they handle it and manipulate it. And that is a problem. Because what you're talking about here is forcing some kind of uniformity amongst plans, and the Managed Risk Medical Insurance Board has been able to do that for the plans that contract with it.

The second think I think that you need to keep in mind about this is that keeping it updated is a tremendous struggle. Health plans will tell you that no sooner do they publish their directories that they're immediately out of date. And currency is also a major problem with this kind of project.

Nevertheless, it can be done. (Inaudible) has one for the HIPC that they publish I think four times a year in hard copy, and of necessity it split up by region of the state because the one super directory for the whole state is just unmanageable.

But they have never been able to figure out a way to get it on the Internet because the costs have been prohibiting them at this point. And they spend about $150,000 a year in producing the super directory.

CHAIRMAN ENTHOVEN: Ron.

MR. WILLIAMS: I think this is one of those things that has enormous appeal. But I think that we spend roughly $2.00 to produce a directory. That's about what a directory costs. You could imagine a super directory, take $2.00, I don't know how much you multiply it by, but it's a big number.

I think that the accuracy challenges of this, the printing of it -- and I think the difference between the HIPC, which is a product focus, and a voluntary association is a plan who has chosen to create a product and collaboratively market that product as one package.

The way the proposal reads, as I understand it, is I would have to take all of Kaiser's physicians, put them in a super directory, which I will get from wherever this comes from, and then open enrollment, distribute a directory that includes all of the physicians in our networks, every other one of my competitors' networks including Kaiser.

CHAIRMAN ENTHOVEN: You wouldn't have to do this.

MR. WILLIAMS: That's what it says, the

plans should be required to update, let's see, um --

CHAIRMAN ENTHOVEN: You provide your information on line, quarterly you update the data bank.

MR. WILLIAMS: No. Hold on one minute, Alain.

(Reviewing document.)

Make it available. Is there reference to open enrollment in here?

DR. NORTHWAY: Plans should be required.

MR. RODGERS: Plans should be required upon member -- potential enrollee requests by telephone to provide a super directory.

MR. WILLIAMS: So we have to actually mail out a super directory.

MS. FINBERG: No. What we have was if I called up and asked what physicians I could be referred to for mental health benefit, that you could give me all of that information upon request.

MR. WILLIAMS: This says the information should be made available to all consumers at the time of enrollment and renewal and to individual consumers at any time. Does that mean when I do an open enrollment, I have to make available to that member at the time of enrollment --

CHAIRMAN ENTHOVEN: No. The idea is that the DOC would do this. The way the HIPC is done is to ask all the health plans quarterly to update their

provider list. And then the DOC will put it together and do a cross-referencing so that you could do just what Barbara said or whatever, with HIPC, that is.

So I want to know in which plans is Dr. Smith participating; so I look her up and there she is, Dr. Barbara Smith, and I look and say, "Which plan is she in?" And then if my -- if the benefits are standardized, for example, I might pick the lowest priced plan that offers my favorite doctor.

MR. WILLIAMS: I guess there would be two things I would say. One is that we're working trying to find ways to make information available before using our product so we can eliminate directories. Because it's an enormous expense and they're used one time and then destroyed.

So you're taking out a two dollar bill, holding it out, looking through it and burning it, yet there's information in there that's very important for the consumer to have. So instead of looking at printing an enormous super directory that is out of date the minute the directory is printed, that would be one issue.

I think the other issue is the concept that this person wants to know what's wrong with the phone call to Dr. Smith to say what plan they're in, that person pays for the phone call as opposed to the entire system. I think there's a product -- it's a different logic to it. It's more of a voluntary

association.

The final comment, if you want to do it, do it electronically, kill the paper, kill the cost, then urge people to pick up the phone and call the doctors' office and find out what plans they're in.

MR. RAMEY: No offense to Dr. Smith, but usually the receptionist that answers the phone doesn't know what plans Dr. Smith is in.

CHAIRMAN ENTHOVEN: Dr. Smith may not know either.

(Laughter.)

Certainly that would be a very friendly amendment, to say no paper, get it on the Internet.

MS. FARBER: Public libraries generally provide (inaudible) --

CHAIRMAN ENTHOVEN: Right.

MS. DECKER: I do think, though, at least I was interpreting the way this was worded is that the intent was that the plans would have the information they fed to the super directory available. So if I called and plan and said, "I want to see Dr. Smith, tell me what primary care physician I could see to get to Smith," that we expect the plans to be able to provide that, which I think they can do today. In other words, you have the data that went into it for your section only.

MR. WILLIAMS: I think, as John indicated, the variability of what each plan can do

will be very substantial. You're talking about very sophisticated database management that needs enormous currency -- doctors change, tax identification numbers. So sometimes I think quite frequently they join groups, they (inaudible), they practice with a group in a different -- and keeping track of that is extremely time consuming. You'll find a way to deal with variability among health plans.

CHAIRMAN ENTHOVEN: We're out of time probably here. Do we have agreement on the concept or should we take a straw vote on just the concept and then we'll rework the language to get out these ambiguities?

Without objection, we'll go to No. 6.

State agency. Jeanne. You're on. No. 6.

MS. FINBERG: This will be a little bit of additional information on grievances. The Department of Corporation has been issuing the past couple of years a report of grievances that they call RFA's, Request for Assistance, and that report does not indicate -- it has numbers and type, but it doesn't distinguish the severity of the complaint or the resolution.

So in other words, I could tell that Plan A only has 5 complaints having to do with telephones and Plan B has 500, but I don't know that out of the 5 complaints there were five deaths whereas

out of the 500 it was a rude receptionist.

So this would add information on the severity of the complaint and urgency, totally related to life and health, and then whatever action was taken either by the plan or the Department of Corporations.

Now, the report does not indicate whether the plan voluntarily resolved the problem or what percentage they did or what percentage the department had to take some type of action.

So this would add that additional information which we think is critical for consumers to be able to use it. Just a list of numbers isn't discriminating enough. So this adds that essential information to that report.

Michael.

MR. SHAPIRO: One of the confusing aspects currently with DOC reporting on complaints is that its only reporting on the complaints that it deals with. In a previous paper, we recommended reporting by plans on complaints that -- they deal with them internally, most of which we hope to get resolved. You've heard that DOC only gets 3 percent of the calls.

One of my suggestions is -- and I'm not sure how to do it -- to integrate defining the current reporting requirement with what we've already approved which is reporting on complaints of the plans. So I think right now it's somewhat unfair to plans if they're successful or not successful resolving it

themselves. It shows up differently if the DOC gets it. All I'm saying is, in dealing with two sets of complaints, some coordination might be called for.

MS. FINBERG: We did adopt that. We adopted that in the dispute resolution discussion and you can probably cross-reference it and maybe encourage the Department of Corporations to make that information available. I think we did the first part. And then solely it relates to complaints that go to DOC.

CHAIRMAN ENTHOVEN: Discussion.

Zatkin. Rodgers.

MR. ZATKIN: I would support Michael's point and suggest that the approach that we use in approving the dispute resolution discussion of grievances be applied here, that is, to look at the nature of the data and through the regulatory process to make sure the data is being -- that the agency is asked to report and for the agency then to come up with a plan to report it if that is feasible, reasonable and not burdensome, which is the test that we used earlier.

MR. SHAPIRO: I don't want to assume that as the Michael plan. The only thing I was suggesting is there is a current report. Existing law requires the report. Consumers are confused when they have a report limited solely to the grievances the DOC handled. That's all they report on. It's a very small fraction.

Versus somehow combining one report or a

project with another report, and that's how the plans are doing it. I don't want to take away from what the department is already doing. That was our thought, to get that report. I'm simply saying someone should recognize that we're doing two kinds of reporting issues.

MR. ZATKIN: I think the same principle applies which is the extent to which one can categorize the grievances. That was an issue in an earlier discussion. That's an issue here. So it seems to me that the same process ought to be applied and establish additional reporting requirements that we arguably make.

MS. FINBERG: I'm not sure if I understand. If what you mean that we can't suggest that these two specific things, that they include the severity and a resolution, then I don't think they're a friendly amendment. I looked at that report a long time, and I think it's critical information. I do think it's available, if possible, and I really do want that specific on that part.

MR. ZATKIN: The discussion earlier acknowledged that establishing categories of severity is not an easy thing. And that was what would have to occur here. It ought to be part of that same discussion.

CHAIRMAN ENTHOVEN: It's like a research project that needs a pilot project to me.

MR. ZATKIN: I wouldn't say in a pilot. I just think it needs to be dealt with thorough the same process that the agency would be using in determining how grievances will be categorized. Ultimately those grievances go to the department. So we're really talking about the same entity.

MS. FINBERG: Except that the department is making the decision. They receive those grievances and they're making an evaluation of those grievances. They're deciding if it's valid or not. So we're not asking them to make a new determination. They're looking at it anyway -- that's their job -- and they're required to by law.

So I'm just saying that they need to report it out. And it could be on a 1 to 5 numerical ranking. It doesn't have to be descriptive, but they are making some determination. And they're also determining whether to bring a compliance action or not.

So they could report out, you know, X number who are No. 1 severity and involve compliance action in two cases. That's information they have. So we're just asking that we be allowed to see it because, without it, we can't utilize the data that we currently get from the department.

MR. SCHLAEGEL: You're saying they've already categorized the nature of the severity? They have classification now?

MS. FINBERG: I don't know if they have classification, but they have to review the grievance to determine whether it's valid or not. And I assume they're looking at the standard in terms of -- in medical injury and so forth. So I'm sure that they are distinguishing between a rude receptionist and loss of life. I mean, they must be. Because how else could they be evaluating the grievance?

CHAIRMAN ENTHOVEN: I could put this to a straw vote if I understood --

MR. LEE: I think that what may be somewhat confusing is that the DOC does a categorization of types of complaints. So we aren't talking about that. But if the language were to say that the department publish reports or publish data on severity, resolution, and calls received, the specific typology to be developed -- and I think that's what Steve is saying -- is that in a collaborative process (inaudible).

But the Task Force is recommending that that be public data. I don't know if they have a severity scale now. But if the Task Force calls for public reporting of severity and resolution, the category is to be determined by a collaborative process. That's in keeping with our earlier discussion.

MR. RAMEY: Let me just clarify it. According to Knox-Keene that I have in front of me,

there is no requirement that they tabulate information on a complaint beyond their sheer number. There was no severity scale --

MR. LEE: There's no mandate in Knox-Keene. I understand that. Jeanne said it's probably true they may do internally collect and tabulate. But I think it's quite reasonable to say that the Task Force say they do report that publicly but the development of what those categories are be part of the review process as we talk more broadly on the grievance side.

MS. FINBERG: The purpose of the report that was put into legislation was to give consumers information to help them in making choices about plans. So I think the fact that it was done this way was an administrative decision that needs changes.

CHAIRMAN ENTHOVEN: Well, I'm struggling here as to how to resolve it. Is along those lines acceptable or do you want to --

MS. FINBERG: Well, I considered the way Peter described it to be a friendly amendment. And if that accommodate's Steve's concern, I think that would do it. I don't know if we have objections to --

CHAIRMAN ENTHOVEN: Steve, does Peter's approach meet yours in terms?

MR. ZATKIN: Yes. I think if it's done in connection with the earlier categorization, we can talk about it.

CHAIRMAN ENTHOVEN: Peter, will you give us wording?

MR. LEE: I will confer appropriately.

MS. FINBERG: I'm sorry to do this, but we have a time problem here because Ellen has a plane to catch; so instead of doing the last couple on this section, we're going to switch over and talk about consumer involvement. And then when that's done, we'll come back to the rest of these recommendations because I want the opportunity to describe those.

CHAIRMAN ENTHOVEN: So we switch over to page 7 under "Recommendations for Consumer Involvement."

MS. SEVERONI: Thank you, Jeanne, very much. I appreciate your willingness to do that and I appreciate the Task Force members' indulgence to shift from one train of thinking into another.

If we can move now to the section on "Consumer Involvement," I would like to help us move through this pretty quickly. I would say that this section takes at its heart the conversations that we had months ago when we discussed some of the issues revolving around the consumer involvement.

And it seems to me at that time that on page 7, as the Chairman noted, the principles for consumer involvement -- there did not seem to be much disagreement among ourselves about the principles or needing to improve the way we involved consumers in

their health care decision making, especially as it relates to our involvement with health plans.

We talk about some very specific issues like member advisory committees and consumer feedback groups and ombudsman programs and ways that these things can be accomplished. And the sense at that point was that we just -- we agreed these are good things and we need to do better.

Our good friend Rebecca Bowen, however, made a point to me at that point in time that she wanted us to get very, very specific. So based on that and on a conversation that we had about member advisory committees themselves are mandated in Knox-Keene, thanks to the good work of Dr. Enthoven's staff, we began to research what exactly was part of the Knox-Keene Act in terms of involving consumers in decision making.

So on page 8 you have before you the language as it currently exists with regard to Knox-Keene. And you can see that there are four bullets here. One, that under (inaudible), HMOs are currently required to establish a governing body which is composed of at least one-third subscribers or enrollees or establish a standing committee which is responsible for public policy participation and whose recommendations and reports are regularly and timely reported to the board. And that the membership of that committee should be at least 51 percent enrollees.

Also, that the plan needs to describe the mechanism by which enrollees can express their views on public policy matters and establish procedures to permit subscribers and enrollees to participate in establishing the public policy of the plan and incorporate these procedures into the plans by law.

Well, based upon what I saw is the consensus saying that we need to do better, I did begin myself a series of conversations with some of the members of my own board of directors and other leaders within the HMO industry to talk a bit about these regulations and that -- about how they worked with member advisory committees within their institutions.

And we decided that we would come back and propose to the Task Force a series of bullets reworking these initial four that I think would hopefully meet the consensus which was that we need to do better and, in fact, draw some more specific lines of accountability for member feedback into the organizations themselves.

So you see before you beginning on page 8 the proposed revision of these regulations, and that's where we would start this discussion. So I would like to at least move through those four bullets, stop there, and then we'll discuss the rest of the recommendations.

The first bullet that remains -- this is kind of like the same, "Establish a governing body

which is composed of at least one-third members or enrollees and ensure that sufficient resources are made available to educate the enrollee board members so that they can effectively participate." The enrollee board members should neither be employees of nor have significant financial interest in the organization or a competitor organization.

Now, the big difference here is instead of having a bullet that said we could have that or what we're recommending here is that we have that representation on the governing body as well as establishing a member advisory committee to ensure that members' values and needs are integrated into the design and implementation, operations and evaluation of the plan.

"This committee shall communicate and advocate for members' needs and serve as a resource for the governing body and plan administrators. It shall be responsible for establishing mechanisms and procedures for enrolling to express their views and concerns. And it should include but not be limited to issues such as benefits and coverage, member communications, quality assurance, marketing and grievance resolution."

And, actually, I have one friendly amendment here already. And that is from our colleague Steve Zatkin, who would like to see that the member advisory committee be plural so it would either be

member advisory committee or committees. And Steve would like to elaborate on that when we get to discussion. I think that would be a good idea considering the size of the structure of many of the plans.

The next bullet would be "Describe the mechanisms and (inaudible) accountability used for obtaining and incorporating member feedback in the policies and practices across all departments and divisions."

And I will share with the group that this specific language came to me from one group of high level people within one of our great California HMOs.

And then in the fourth bullet, that we would demonstrate how member feedback would be incorporated into plan policy operations and evaluation.

CHAIRMAN ENTHOVEN: Discussion.

Yes. Helen Rodriguez-Trias.

DR. RODRIGUEZ-TRIAS: I really like this very much, and I wondered whether we could incorporate some of the vulnerable populations recommendation into that, specifically that there be sufficient representation from vulnerable groups in the government structure.

MS. SEVERONI: It's an interesting comment, Helen, because this second bullet of the member advisory committee bullet is the model program

that we established in the CALOPSIN (phonetic) plan. So in that sense it certainly does represent one vulnerable population, Medi-Cal population.

DR. RODRIGUEZ-TRIAS: Right. But I must testify that I know that people with disabilities bring this up very often, and I guess that's because that's sort of the most obvious constituency that has developed legislation of its own and so on that the issue is one of representation as well, that just because they're consumers in general doesn't necessarily represent the vulnerable population.

CHAIRMAN ENTHOVEN: Any other discussion?

Ron.

MR. WILLIAMS: I think that -- I think we all agree and I would certainly agree that developing the right method to ensure consumer input into the health plan is important. I think I'm concerned about some of these recommendations because they confuse what I think of as market responsiveness with the fundamental governing objectives of the organization, which I view as assuring long-term success of the organization by delivering high quality, clinical, appropriate care through the networks and providers that it works with.

It's also being certain that the organization has proper access to capital, has the right information systems, it has the right marketing strategies and marketing plans and that it's

financially stable. And that it is there at the end of the day to pay the providers and make certain that the organization is going to be around to meet those expectations.

So I think the part I get confused about is I think the original Knox-Keene code appropriately recognized is that there are dual obligations and that there are multiple ways to accomplish those objectives. And my concern is we'll end up with an imbalance in which we will have not just at a given point but we will have in a given plan an extremely responsive organization that has the potential to be financially broke and not physically responsible in terms of making all of the appropriate tradeoffs.

I have to say that I worry about health care in California. We're going to have the most well informed, knowledgeable and smallest group of insured human beings in the state if we continue to do things that are very, very desirable from a long-term objective.

Think about every time you turn on the copy machine and make one copy, we just increased a person's paperwork. One copy is all we have to make. I'd say in this meeting today we probably generated 10- or 20,000 copies.

So I think this is a tradeoff. I think the work that has gone into this is very commendable. I think you and the entire team has done an excellent

job. But it's the horns of this dilemma that we're on which I don't have any easy answers for, but I can tell you it's a challenge.

DR. ROMERO: Just a clarifying question of Ron. Ron, your comment is exclusively to the first bullet? It sounds like you're talking mainly about the first four bullets.

MR. WILLIAMS: Well, that's the "protected" one. I'm sorry.

CHAIRMAN ENTHOVEN: John Ramey.

MR. RAMEY: I kind of gathered by this discussion that some folks suggest ways that we would essentially develop a market-driven system for the distribution of health care in the state. But, nevertheless, that is what we have.

We all believe, I think, the consumer information and choice in that process. In other words, we want folks to make well-informed decisions; however, I think it is a mistake and a giant step in the wrong direction to say that we're going to put consumers in the position of governing the health plans in a very significant way.

And if we're going to make that decision, why should we stop there? I think that every doctors' office should have patients on its governing board so that every doctor can be responsive to those patients. I would expand it to hospitals in the same way, every hospitals' governing entity must have patients on it.

DR. NORTHWAY: They do.

MR. RAMEY: Well, they don't to the extent that I think that they have advisory (inaudible). So I think that this is, in terms of governance, is let the consumer be informed and let the consumer make a wise decision. We all support that. But putting the consumer necessarily in control of the health plan is not the way to make the market work.

CHAIRMAN ENTHOVEN: Other comments? Nancy. Dave.

MS. FARBER: I would like to comment on the constituency of hospital boards. I work at a hospital that has five publicly elected members from the community performing the governance. It works just fine. There are 65 such hospitals in the state of California. They're all hospital district. Having the public participate has not been a destructive (inaudible) than good. It's a breath of fresh air.

Many of the nonprofit community hospitals also have community representation. I worked at Hoag Hospital in Newport Beach. One-third of that board came from the community, a very successful hospital. Public participation is not destructive.

CHAIRMAN ENTHOVEN: Steve.

MR. ZATKIN: My issue is not with the first two bullets but with the third and forth. Because I think, as I've indicated to Jeanne and Ellen -- at least Ellen, that in the first place,

having those kinds of provisions if they're in regulation will result in a lot of effort by the plans to document that they did this and they did that. So a lot of paperwork which in the end won't necessarily guarantee real consumer involvement.

A plan that wants to have substantial consumer involvement will have substantial consumer involvement, and a plan that really is resistant will find a way to provide the documentation for that. And I really think that the first two bullets provide a basis for formalized consumer involvement. But I would recommend avoiding what will become a series of reports in the third and forth bullet, which will not in the end achieve the goals but will largely result in just a lot of paper.

CHAIRMAN ENTHOVEN: Alpert.

DR. ALPERT: I have quite a bit of experience in consumer involvement in medical decisions. 40 percent of the medical board of California are consumers who are advising a hundred thousand licenses to practice medicine and not only does it work well but I've never seen any either doctors or consumers vote as a block. It's been a very constructive relationship.

MR. SCHLAEGEL: I appreciate the paper and its goals and objectives of trying to get consumers involved. In fact, I think it is an important part of changing the health care system. As somebody who also

spends $150 million a year on health care, I am concerned about how many Xerox copies we're making and this paper flow.

And I guess what I'll do -- Ron, I would like to ask you a question. It would seem that at some point just as computer companies and software companies start having user groups who advise them on what they need going forward, it would seem to me that the enlightened health plans would start to see that these advisory groups are the way of the future and that out of self-preservation would establish as such.

MR. WILLIAMS: I think that's wonderful. I would agree 100 percent with you, Les. I know our health plans and current code requires that there be consumer groups. We have a public policy committee. It has a large number of members who are enrollees. It's a very structured agenda.

I think from the point of view of market place success, the smart businesses want to understand their consumer so that they can grow and prosper by meeting that consumer's needs and expectations. As I said, I think it's excellent work here. And I think that all health plans I think are well-served and have a very strong connection with consumers because they buy the product, they use the service.

So I would agree a hundred percent with you. Where I draw the line, it is moving from something where that is an advisory group where it

becomes a central part of your governance process and -- whereas I think it's worked very well at least in our case from my advisory committee. We got lots of good insight as a result of listening to what consumers say. And sometimes they tell us things that we'd rather not hear, but they're important for us to hear and understand.

CHAIRMAN ENTHOVEN: Ellen, I put myself on the list at this point. I think that main thrust of what you're trying to do is wonderful, and I agree with your assessments that the health plans, partly because of the market structure or they see the customers and the employer -- rather, the employee gets to the choice issue, stuff like that.

But I share the feeling they haven't done enough to seriously involve consumers, and I applaud the work you do and wish that that were general. I feel that on the first part of it that -- I feel I need to vote against it because it proposes to set a precedent for government tampering with boards of directors of publicly held companies.

And I think that raises large constitutional and other issues, that is, members of boards of directors of publicly held companies have fiduciary responsibilities and can be sued if they fail to discharge those fiduciary responsibilities. I'm impressed by -- favorably by the PERS' board of administration which has gone after a lot of

managements for poor performance and for board members that are lazy, ineffective or what have you and has demanded that board members -- this is on the pension side, of course -- meet higher standards.

And I've always understood it to be the board members' responsibility is to the shareholders. Of course, to discharge your responsibility to the shareholders effectively and successfully, you'd better pay a lot of attention to the customers, the employees, and other stakeholders. And that there's even something wrong -- I believe there's something wrong with somebody being on the board of directors of a publicly held company and is not a shareholder.

When I went on the board of PCS company, for example, I told them I'm a mere and poor professor; so I can't invest the way you guys do, but I will tell you I'm going to buy enough shares that, if this company does poorly, it'll hurt so that you know I'm here looking out for the shareholders. Now, that's kind of coming at this whole thing from an entirely different direction but when we --

MS. SEVERONI: Also, we're the organizations that are for profit. Not all of them are.

CHAIRMAN ENTHOVEN: Right.

So when you went from "or" to "and," I just felt sort of like unconscious that -- I expect I'll lose the vote, but I just think unconscious,

that's it not the right thing to go for.

MS. SEVERONI: Also, I just (inaudible) very clear with us about that. But from an overall perspective, one of the things we wanted to say here is that member input is lacking at all levels of plan operation and implementation. And that includes governance. So it would seem strange, I think from my perspective, to advocate what goes into every level but governance.

VICE CHAIRMAN KERR: I myself agreeing with everybody, which is a problem because there's contradictory (inaudible), I'm wondering if at a minimum, since I think it's a split vote, at a minimum anyway it could be publicly and visibly reported at least what percent of enrollees and members are on the governing board.

So it's clear when people make a choice of plans that they would know whether there is a high or low percent of enrollees and members who are on the governing board and then they can make a decision whether or not that's important to them in their choice of plans.

MS. SEVERONI: When I talked to the president of Health Net, he reminds me that all of his board members are enrollees in the health plan yet they wouldn't meet this criteria of not having the financial --

VICE CHAIRMAN KERR: And make it specific

so that you could bring out the information about the financials.

CHAIRMAN ENTHOVEN: Because they're expected to be stockholders.

VICE CHAIRMAN KERR: In other words, so you could bona fide who are people who do not have the financial investment, the types of things you're asking here, but let it be information to the public who may choose the plan as opposed to requirement of the evidence.

CHAIRMAN ENTHOVEN: Jeanne.

MS. FINBERG: I think what Clark said "at a very minimum" is a good one, but I'm wondering if there isn't a little bit more that we would do here and maybe it's to, say, change the percentage. This has the one-third requirement. I'm wondering if people would feel differently if it was a much smaller percentage and that we did have this requirement but had it be 10 percent instead of one-third. I took -- just pulled that out of a hat, but I was offering up a lower representation so that -- if you follow some of the sentiment that people have indicated, that they agree with.

CHAIRMAN ENTHOVEN: Michael.

MR. SHAPIRO: Just a point of information. There is some existing law on this. I regret again I didn't bring my Knox-Keene Act. There is a provision in the Knox-Keene Act that requires the

plans as part of their public policy concerns to consider enrollee views. We looked at that issue two years ago. It was a low priority issue, but we concluded that it wasn't being done.

Now, I tend to lean on these are private corporations. You create significant problems if you try to put folks on the governing board. The options we considered two years ago were formalized. The advisory committee or committees rules -- it's not uniformly done -- can require a survey of your enrollees for that advisory committee to make sure that that kind of information was used in considering the policy.

They're not part of the governance, but you basically assure to an advisory committee input on major policy issues from your enrollees. Those were simply not considered priority issues. But someone should look at existing law. There is some reference to --

CHAIRMAN ENTHOVEN: It's in the paper we quoted. Michael, we did go back in our long arm wrestling on this. We stated what the law says. My sticking point with my dear friend over here is "and" or "or."

MR. SHAPIRO: We were just looking at the advisory capacity. But to make it more certain that it would occur because it wasn't happening.

CHAIRMAN ENTHOVEN: Jeanne, my concerns

are sort of principal. I think directors are supposed to have fiduciary responsibility and be --

MS. FINBERG: It's now provided as an option and the problem is that none of us have chosen that option. And so what we're trying to do is to encourage or have something that would move towards something that the Legislature viewed as an appropriate option.

So I -- maybe there is no percentage that would work and we could just straw poll it, but I just wondered if -- for those that did object to it, you know, if a very small percentage would be more acceptable.

CHAIRMAN ENTHOVEN: Could we straw poll the Kerr amendment first, that is to say -- I mean, I want to do this in a way that you feel is fair. Clark was proposing to say we replace this requirement, the "and," with the closure. I want to -- may we vote on that?

MS. FARBER: Could I ask a question? I want to make sure I understood what Michael Shapiro was saying. Were you saying that if the plans currently were in breach, then otherwise the requirement for an advisory board?

MR. SHAPIRO: What I'm saying is when we looked at this issue two years ago, this issue was raised as a concern. It wasn't a high priority concern in consumer groups. And there was a sense that there

wasn't good faith efforts to comply with existing law which gave you these options.

What we were considering at the time was to mandate a combination of the advisory committee in combination with the survey; so you had assurance that you had really representation on an advisory group, assurance that they were getting the benefit of broad information in the survey but they weren't governments.

MS. FARBER: I want to make sure I understand. If the Knox-Keene Act requires the plans to have these advisory boards and the industry is flagrantly in violation of it and if it's not a --

MR. SHAPIRO: No. That's not what I said. I said existing law wasn't -- they weren't in violation. It simply wasn't compelling enough to make a significant difference. We were looking at ways of toughening the law to ensure we had the feedback from enrollees to the plans.

MS. FARBER: How did you determine that these plans did not have their advisory groups governing?

MR. SHAPIRO: We had testimony.

CHAIRMAN ENTHOVEN: But it's mushy language just like everything else in Knox-Keene.

MS. FARBER: So we have an industry that's already shown a prevalence in which they're avoiding --

MR. SHAPIRO: The answer is no.

CHAIRMAN ENTHOVEN: Les?

MR. SCHLAEGEL: I guess, if I had my brothers, I would rather go out and really start enforcing the language that's already in Knox-Keene to start diminishing the number of people on the governing boards. We have one vote at the table versus 15 (inaudible) where in here you have a structure that says you must go out and do the surveys, you must take it into consideration, at least it gets into the minutes what the consumers want. I'm concerned about that one voice being up against the rest of the board. I think this would be much more effective.

MS. SEVERONI: You're speaking about the second bullet which really talks about the strengthened advisory committee.

CHAIRMAN ENTHOVEN: Let's try to take a straw vote on Clark's proposal that we substitute language that requires disclosure for requiring the governing board to have members.

MR. LEE: We should probably have the votes for for it. That's a vote that everybody will vote for. And even though it's the "or" or the "and."

DR. ROMERO: Good point.

MS. FINBERG: I think you should do the original first.

CHAIRMAN ENTHOVEN: Okay. So we'll take a straw vote on the language as submitted --

MR. LEE: On the word "and."

CHAIRMAN ENTHOVEN: -- on the first bullet with the word "and" in it.

DR. ROMERO: One-third governance.

CHAIRMAN ENTHOVEN: So all those in favor, please raise your right hand.

We're voting on the original -- well, it's the pair of bullets, the first two bullets which are linked by "and" on the bottom of page 8 and the top of page 9. And a vote -- raising your right hand means you're in favor of adopting the language. If we don't favor adopting that language, then we'll consider Clark Kerr's amendment.

So all in favor of that language, please raise your right hand.

(Committee voting.)

CHAIRMAN ENTHOVEN: Seven.

All opposed?

(Committee voting.)

Eight are opposed. Okay.

Then we will next take up Clark Kerr's amendment which -- do you have this language?

DR. ROMERO: Yes.

VICE CHAIRMAN KERR: It would say the plans would publicly have to disclose how many members, enrollees they have on their government support that had no financial interest in the corporation and perhaps even something about how long they've actually been enrollees or members of the health plan. And then

people who are choosing a health plan would have that information along with other information to determine whether or not there was support making the choice qualified.

MR. SCHLAEGEL: And then you go on to "and" from that.

VICE CHAIRMAN KERR: Yes. The "and" or the vice-versa.

MR. LEE: Just following on a couple of other amendments, we changed under this, this "and" to "or" based on the prior vote. I think the other language still applies even if to change Knox-Keene to make it clear who is -- if they do have a board member, that it still would fit there, no conflicts of interest, as was stated in there.

CHAIRMAN ENTHOVEN: There is a catch 22 here which is board members are supposed to --

MR. TIRAPELLE: Not only a catch 22. Once these consumer advocates become board members, they become fiduciaries for publicly held companies. So it doesn't matter how many they have on there if they're doing their job and they're carrying out their fiduciary responsibility; and if they're not, they're individually held liable for not doing so. So I don't know -- I appreciate the attempt, Clark, to find some midground here, but I'm not sure that what we're doing is really not misleading because these consumers should now be fiduciaries.

VICE CHAIRMAN KERR: But it's a question of whether they owned stock, for instance, (inaudible) profit. It's whether they were put there because they have a financial risk to, you know, other than being a consumer and enrollee for sales, trying to differentiate so people can (inaudible) sell plans, made a bona fide effort to bring on people who have no apparent financial reason beyond there other than to do a good job for the consumers enrollees not because they're going to (inaudible).

MR. WILLIAMS: Clark, I think we're missing the word fiduciary. Maybe we can get a lawyer in the room to help us out. Once they become a member of that board, they have an obligation to the board.

MS. FINBERG: The law requires that; so that would be true regardless of what we adopt or if members have that fiduciary duty (inaudible).

VICE CHAIRMAN KERR: That's different than owning stock in the company.

CHAIRMAN ENTHOVEN: In which case owning stock does not give you a conflict of interest. It reenforces your concession.

DR. ROMERO: Precisely. That's why most boards are expected to own stock.

MR. WILLIAMS: Whether they own stock or not, they have to act like a person who owns stock.

MS. FINBERG: That's different --

CHAIRMAN ENTHOVEN: We have to move. We

will take a vote now on Clark Kerr's amended version of this which is disclosure, how many members of the board have no financial interest -- all in favor, raise your right hand.

(Committee voting.)

CHAIRMAN ENTHOVEN: 11. All opposed?

(Committee voting.)

CHAIRMAN ENTHOVEN: But Clark's amendment, disclosure amendment carried; right?

MS. SINGH: Right.

CHAIRMAN ENTHOVEN: Okay. Thank you.

The next one, we'll go to point 2. Purchasers, employer groups, including government agencies contracting for health care, should --

MR. ZATKIN: What happened to 3 and 4?

CHAIRMAN ENTHOVEN: Sorry. Bullet 3. I mean, the -- it's the third bullet under Item 1 describes the mechanisms. Okay. By a show of hands, all in favor, raise your right hand.

MR. ZATKIN: We had no discussion. I pointed out a problem. This says we have to show how consumer involvement affects our finance department. This is all -- across all departments and divisions. That's -- I think that makes no sense to me.

DR. NORTHWAY: You're talking about the third bullet, not No. 3?

MR. ZATKIN: Yes.

CHAIRMAN ENTHOVEN: Finance department,

purchasing department. Maintenance department could be pretty important if the floors are dirty.

MS. FINBERG: We need to try -- Ellen needs to catch a plane so if we could get the critical discussions.

CHAIRMAN ENTHOVEN: Ellen, which one should we take up next?

MR. LEE: Could I suggest on that one, on those bullets that, Steve, you can suggest the language. No one wants to be able to generate huge reports that aren't useful. Some methods could be useful with the types of coverage, member communication, quality assurance, grievance -- in those areas. So pull those bullets, 3 and 4, into one bullet then describe some description of how member consumer input is incorporated to these issues.

MR. ZATKIN: Do you want to do that, Peter?

MS. DECKER: Does this already exist by any chance in any of the accreditation processes?

MS. FARBER: In hospitals you'll find you have to demonstrate across every department in the hospital how (inaudible) statement --

MR. WILLIAMS: It's also part of the NCQA accreditation. You have to show how you have improved the quality of the health services to consider --

MS. FARBER: I've been asked by Les if I think it's useful. And I guess the answer to that

question is, yes, that I think it is.

CHAIRMAN ENTHOVEN: Let's see. Ellen, in deference to you -- I'm sorry it's taking so long -- of the two, three, four and six items here, which do you want -- what would you like to do?

MS. SEVERONI: Are we okay on the bullet section moving through now with some amended language? Is that the agreement?

CHAIRMAN ENTHOVEN: Lee's reworked into one bullet, try to make it like NCQA.

MS. SEVERONI: I want to be very, very clear that I think it is important now for the agency that overseas Knox-Keene, whomever that turns out to be, whether it's OHO or OSO or whichever, that we really are able within the plans to do the bullets No. 3 and No. 4. And that is described exactly, what the mechanisms are for incorporating this member feedback into policies and practices and then to demonstrate that you have done it.

CHAIRMAN ENTHOVEN: This is not necessarily a periodic report; right?

MS. SEVERONI: No. This is -- as those -- and I agree that NCQA is doing it more. And as I discussed it with them, this is something they want to be looking at even more. The President's commission itself is looking for it, how member communication mechanisms can be brought in. Okay. We can move on. Then let's move to 2.

The Task Force -- again, I'm hoping we can recommend the following four bullets, and they should be two, three, four and five. Six is just a typo. And also in the one marked No. 4, the last three words "should be encouraged" should be stricken. That's a typo.

So on the second line, "purchasing employer groups, including government agencies contracted for health care, should be exercising their bargaining power to encourage plans to insure that medical and other provider groups develop and utilize mechanisms of consumer feedback."

Are there objections to that?

CHAIRMAN ENTHOVEN: I hear no objections.

Next.

MS. SEVERONI: Number 3. Accrediting bodies like NCQA, JCAHO, BAT and whatever other outfits should develop standards regarding plans and provider groups, utilization of consumer feedback and policy development and implementation.

CHAIRMAN ENTHOVEN: Any objections

MR. WILLIAMS: I want to request that consumer feedback be validated. We saw yesterday something like 70 percent of the people with (inaudible) if it were less than $20.00.

CHAIRMAN ENTHOVEN: Let's see. That's in point 3.

MR. WILLIAMS: Yes. Utilization --

MR. LEE: How about validated reliable?

MS. SINGH: That's the same thing.

MS. SEVERONI: This would be consumer feedback, Ron, that you would be gathering in terms of yourself.

CHAIRMAN ENTHOVEN: Number 3 as amended by Ron is "validated reasonable, reliable consumer feedback." Okay.

Number 4.

MS. SEVERONI: "The task force encourages collaborative efforts among government, foundations, plans, provider groups and purchasers to final expansion of organized systems of consumer involvement."

What we might be looking at there, for instance, is -- I can only give you an example of California Health Decisions. Recently we had several foundations approach us and take the consumer feedback group and say that they would like to see that applied to Medi-Cal managed care. And so they encouraged us to move forward and develop that same process there.

What we will be looking for here would be other efforts like that among these parties to continue that process of organized input.

CHAIRMAN ENTHOVEN: Any objections?

I hear none.

Number 5.

MS. SEVERONI: The appropriate managed

care oversight agencies, whatever those appropriate agencies turn out to be, should have member advisory committees themselves responsible for ensuring that managed care plan members' values and needs are integrated into the collection of information from and regulation of managed care organizations.

CHAIRMAN ENTHOVEN: Do I hear any objection?

All right. Without objection.

Ellen, I want to thank you very much. You've done an enormous amount of work on this, and I think it's really very valuable, your whole point. If people had paid more attention to you across America, we wouldn't be having this managed care backlash, at least from the consumer side. I appreciate it very much.

MS. SEVERONI: Well, I just want to say again, I really appreciate, Mr. Chairman, you and your staff and also the Executive Director and the involved parties there for working so hard with us so that we could bring it to you in this fashion.

CHAIRMAN ENTHOVEN: Thank you very much. Have a safe trip home. Happy Thanksgiving.

Let's see. Jeanne.

MS. FINBERG: Move back to page 5, No. 7.

CHAIRMAN ENTHOVEN: Could I just say something about the state agency, something I'm planning to do after we get these papers turned around.

I'm going to fax everybody on the Task Force and ask you to nominate a name for the agency -- SOSO, OSO, whatever -- and then that is going to be recycled back to the Task Force members to vote on and the winning entry is going to receive a very nice bottle of wine from me as a prize. And the winning one we will try to conform all the papers to that name without objection.

MS. FINBERG: Number 7, the state agency should support and find in collaboration with the private sector to gather additional patient satisfaction and quality data both at the provider group and plan level. And then we give some examples that are good models of this type of thing.

Comments? Objections?

CHAIRMAN ENTHOVEN: The key thing about this, of course, is when you get some of the mega HMOs, the care is delivered at the group or IPA site and telling how Health Net versus Pacific Care does doesn't tell you a lot when what you really want to know is, like I said, (inaudible). Is there any objection to that?

MS. FINBERG: Maybe we can add in the word "standardized." I realize as I'm looking at it that we're not encouraging standardization which is something that (inaudible).

CHAIRMAN ENTHOVEN: Standardized patient quality data, standardized data.

MR. LEE: I think it's a great

recommendation. One thing that I think that -- the intent, though, is to fill in the gaps where these private efforts aren't covering particular plans and medical groups. I think -- that's what I hope the intent is. If that is the intent, maybe we should state it.

So the intent is to duplicate what PBGH is doing. But if there's -- because of that there are four plans that the market rolled in, the point is to roll them in so we capture the entire market. Is that a fair statement of the intent?

MS. FINBERG: I think that's right, and we'll add that language and try to fill in the gaps that are missing.

MR. LEE: Right. Not to duplicate what's already being done, but to make sure that we capture the whole market.

CHAIRMAN ENTHOVEN: Good. Okay. Number 8.

MR. WILLIAMS: One question.

CHAIRMAN ENTHOVEN: Sorry.

MR. WILLIAMS: The only question I had was on the funding question which is, again, we're increasing costs. Clearly I think we want to be certain that the entire market is surveyed and that there is that -- is it the role of the regulatory agency to find survey research on particular entities? If that's true, I know a lot of health plans that might

want to stop funding their own research in order to save the paperwork. So that' why we have the policy question.

CHAIRMAN ENTHOVEN: What do you think about that, Jeanne?

MS. FINBERG: I like the idea of standardized research and would like to see the plans work together with the regulator to have one effort.

CHAIRMAN ENTHOVEN: One thing about this now is -- of course that's at the plan level. Between PBGH and PERS, they get 95 percent of the HMO members. So it becomes a whole other story when you get down to the participating care groups. That's much more diffused.

MS. FINBERG: I'm not sure we want to address the funding at this point. We haven't done that for most of our recommendations.

CHAIRMAN ENTHOVEN: I suppose it is a problem. If you want to get a statistically significant sample at the -- down at the care group level, you have to have a big increases.

Bruce.

DR. SPURLOCK: That was exactly my point. I'm actually (inaudible) because we do this at CCHRI. And it's a big issue on funding and drilling down the provider level is really two or three words with magnitude more in cost because the sample size has to increase.

So just to give people an example, when we do patient satisfaction surveys at the plan level at CCHRI and we do it for all -- I think there are 22 plans that are involved in CCHRI that are (inaudible) but I think we only missed two or three.

We sampled 423 people -- that's sort of the sample size -- to make sure that that process is accurate. We oversampled a couple of other areas to make sure it's a valid process. But we do 423 per health plan.

If you think by doing that to the medical group level, remember, medical groups range in size process from 3 or 4 all the way up to 3- or 4,000. You're talking about a huge magnitude or multimagnitude is the word increase in the number of samples to be able to do that to accomplish that data.

So, again, the cost becomes astronomical and we're just itching to find a way to be able to fund this. Because we know how to do it. We just don't have the mechanism to make it happen in a fast way because of the funding issue.

DR. KARPF: I hate to be skeptical. If the state funds it, I have a feeling it's going to come out of premium tax on providers and plans.

MR. LEE: I'd just suggest for the time being we reword the introduction so to not say "fund" but say "to encourage and support these efforts such that it does cover the entire population." Now, that

may mean for those plans that aren't doing it there's a mandate on their funding it. But you don't want to double tax the providers that are already doing this.

DR. KARPF: The point that Bruce makes about group numbers I think is a very important one. We really want to do something that's manageable. We have to have some kind of cutoff that will be functional whether it's 50 physicians in a group, 100 physicians in a group, where numbers supplied is covered.

MR. LEE: I'm sure that's a friendly amendment. Provider groups to a reasonable threshold size.

DR. ROMERO: And group groups or something like that.

CHAIRMAN ENTHOVEN: Group groups, smaller groups until we get up to a hundred or something. I don't know.

DR. ROMERO: 10,000, 20,000 lives.

MS. FINBERG: Let's not worry about detail. So groups down to a certain size and we won't specify what it is. Okay?

CHAIRMAN ENTHOVEN: Next?

MS. FINBERG: Number 8 is for employers to segregate out the amount of money that they are spending for their employees on health care. And this was a suggestion made so that consumers become more conscious of what they're getting as part of their

wages in addition to the out-of-pocket expenses that presumably they are aware of.

DR. ROMERO: And this is not mandated. This is encouragement; right?

MS. FINBERG: Right.

CHAIRMAN ENTHOVEN: Barbara?

MS. DECKER: I just want to mention that I think the general direction you'll find most of the larger employers are going, they are trying to attribute contributions to health care, other contributions for other benefits. It's total compensation. We don't tell you how to spend the money we give you. You get to choose.

I agree this is a good concept. We certainly try to tell our employees what they are getting in a subsidy toward their health care dollars. We're trying to take it away and saying it's health dollars. We're just saying it's benefit dollars.

MS. FINBERG: So it wouldn't prohibit employers that group health in terms of other benefits from doing that.

CHAIRMAN ENTHOVEN: I think it's a principle with which we all have to agree. I think a big contributor to our problem is people had no idea how much this has cost; so this is enhancing their awareness.

So without objection.

Jeanne, thank you very much.

Now, we have two people from the public and then we want to move quickly to integration and women.

Maureen O'Haren and Catherine Dodd will each --

MS. O'HAREN: Thank you, Mr. Chairman. I think with some of the agreements on the consumer involvement part, I'll leave that for additional discussion and amendment. But I'd like to comment on amendments in the first part.

I think on the publication that's part of Recommendation 1, I think we have to question, first of all, whether anyone will really read this. We have a hard enough time getting people to read documents pertaining to the very plan that they have enrolled in.

I would find it very surprising if those people would take the time to read something that is generic, especially if the paper points out. Most people, what they really want in terms of information is information specific to them. So if we can just get a way of people to read their own materials, I think that would be progress. And another generic publication probably won't help.

I think Recommendation 2 is duplicative of other recommendations in the standardization of health benefits paper as well as the recommendation of practice of medicine paper.

I think Recommendation 3, there's really

a similar recommendation in the patient-physician relationship dealing with -- and I don't know what happened with that recommendation. But there was one that would require the providers to provide the information on how often they do certain procedures.

I really think it's the obligation of the provider to provide information to a patient that has to undergo something and not really the plan trying to aggregate all this information. I think there are so many data obligations in the plan right now in terms of disclosure and descriptions that there -- this would just be another thing that's not -- in addition, it's not integrated into other data elements that this report has dealt with.

Recommendation 4 dealing with criteria, I think there are a lot of plans that hold this to be proprietary, and we would not want to disclose this -- all of it, anyway, to an enrollee. I think Steve Zatkin's comments were on point in this regard. It should only be disclosed to an enrollee or their family member with regard to a condition that they are currently involved with.

Recommendation 5, the super directory. One thing that ought to be considered is the fact that the medical board currently has an Internet site that that has physician information. Though Ron Joseph has told me that it's not an adequate system and it needs more funding and some upgrades, that would probably be

a better place to look to build a super directory. And the physicians would have the greatest incentive to make sure it's updated in terms of what plans they contract with. It also has other physician specific data right there for consumers to look to. So we think, in order to save resources, that ought to be a place to consider.

Recommendation 6 regarding the DOC complaint report, if what is required is aggregate data about aggregate actions taken by the DOC -- the language right now says the DOC should indicate what action it took in response to the complaint as if what is requested here is action on each complaint.

And then on Recommendation 7 regarding the quality data, I think that the state should not duplicate what's going on in the private sector right now. And certainly we would be concerned that, if the state did get involved with this, yes, it would come out of health plan licensing fees or some other health plan funded source. And if the DMV computer system is an example, it will be more expensive than it would be to get it done by the private sector and possibly not very efficient. So we have concerns about that, too.

CHAIRMAN ENTHOVEN: Thank you.

Catherine Dodd.

MS. DODD: Catherine Dodd, American Nurses Association of California. I don't have a joke today. But I do want to comment on Recommendation

No. 5.

I urge that the super directory idea be pursued. I believe that if provider choice, provider information were available, it would actually promote the market based on quality and based on recognition. A concern when health plans say that they're concerned about the cost of photocopying, perhaps they might consider cutting the budget from marketing materials like pens and clips and other giveaways, which I see many people going home with bag loads of during open enrollment. And let the consumers choose their plan based on who the providers are and how they practice rather than spend money on marketing trinkets.

Specifically I'd like to request that that information regarding who the providers are -- and I don't think we would be able to do it through the medical board's web site, but that all providers be included and currently nurse practitioners, nurse midwifes and physicians' assistants are frequently not listed on the plan, on marketing material to consumers, specifically in the counties where the ratio of physicians to people is high.

If you look at your maps that are in one of the documents, where there are a lot of docs, somehow the health plans refuse to list the physicians' assistants, nurse midwifes or nurse practitioners so the consumers don't have the opportunity to choose. And I have known people to spend entire days calling

from medical group to medical group, from plan to plan, to try to find a place where they can be delivered and receive their care from a nurse midwife or a nurse practitioner, et cetera.

I don't want to be categorized as though, if we have to do that, then we have to list all the podiatrists, et cetera, et cetera. We're not podiatrists. We're providing primary care in collaboration with physicians, and physicians want to choose us. We are a cost-effective choice and only you -- or only the Legislature can mandate that that choice be available to all health care consumers. Thank you.

CHAIRMAN ENTHOVEN: Thank you very much.

We'll have a two-minute stretch, and then we're going to move to the paper on integration, a case study on women.

(Break.)

CHAIRMAN ENTHOVEN: Members, please resume their seats. In just a moment Dr. Helen Rodriguez-Trias will begin the discussion of integration of health care and the role of women.

However, let me just take a quick moment. We have all received a letter to me from the California Association of Catholic Hospitals noting that we have written in various places that health care -- health insurance is an important public policy problem because health care is a special moral status. Most people

consider it unacceptable to suffer or be disabled or have shortened lives for lack of ability to pay for medical care, et cetera.

I hope those words didn't die with our abandonment of the paper on the role of government and the public/private sector mix. But, anyway, they agree with that. Therefore, the association believes that, as part of the deliberations about vulnerable populations, the Task Force should recommend the following.

The recommendation is the California Legislature should establish a working body of experts and relevant stakeholders to cover the areas of concern which were demonstrated but not within the scope of the Task Force work, including but not limited to examination of the status of health insurance coverage in California, determination of why there are substantial populations not covered by health insurance, et cetera.

I'm just reading it now to sort of have it in the record of this meeting which gives us a license to come back to talk about what we do about this in the final meeting. I was thinking in my Chairman's letter at the beginning -- I was a little facetious last time when I said it would just have two lines. Although I pushed to that, I might fall back to it.

But I would like to write a paragraph on

this issue and say, following up on Maryann's idea, there are very important things we didn't get to. And the fact that we didn't get to them doesn't mean we don't think they're important. And the boundaries between managed care and other things are sometimes blurred.

But the Task Force considers this to be a very important issue and kind of explained some of the reasons why nobody on the Task Force believes that people should suffer, die, have their development impaired for lack of access to medical care and some kind of a call for continued progress, whether we want to call for another blue ribbon task force or not.

I was thinking of handling it that way. But we could also think of handling it in the context of the paper on vulnerable populations. I would prefer we not discuss it now. I'm just speaking about it to kind of create a license for further discussion. I'll now turn the floor over to Dr. Helen Rodriguez-Trias. We really will end at five o'clock. I apologize for the time element.

DR. RODRIGUEZ-TRIAS: Our time is running very short. I will really go directly to the recommendations unless anyone wants any discussion on the rationale for this paper. And so we can turn to page 5 coming to the top.

In the primary issues that we were attempting to address with this is that women are the

primary consumers of health care for themselves and their families and as such are actually perhaps most affected by some of the issues around fragmentation of services and the separation of services that they themselves need from one side to another, particularly because traditionally reproductive health services have been provided as a separate part of the health care system by and large. That's the historical reason for that.

So in the recommendations, I think we can begin with the first one, managed care organizations to be encouraged to coordinate and integrate care around the needs of members.

Much of this is contained, actually, in some of the other papers; so I won't dwell on what is repetitive. Advocacy groups should work with purchasers and accrediting organizations to define member survey questions that measure the extent to which MCOs are effectively integrating and coordinating members' cares.

Then, two, recognizing that members, particularly women and adolescents, are likely to forgo care because of issues of scheduling and confidentiality. This is very particular to this paper. Managed care organizations should address these specifically as issues of practice.

When managed care organizations refer members to community-based clinics for medically

necessary services not available within the plan or recognize that many of the members are self-referring to these facilities, MCO should be encouraged to provide an option that allows reimbursement for necessary, primary and preventive care at alternate sites.

This is particularly important where the traditional -- where for large numbers of women the traditional provider may be a voluntary organization such as planned parenthood or a similar program where they have been receiving reproductive health services and now they're coming into managed care for their coverage but continue to use those as provider for their reproductive health.

A plan should be encouraged by purchasers to provide information to plan enrollees, not only the primary plan subscriber, to ensure that those plan members covered as dependents are aware of the services available to them.

I think this is pretty well covered in the consumer information.

The division between primary care and routine reproductive care for women results in fragmentation of services which may be unnecessary -- I'm inserting here -- an unnecessary duplication of services or cause inconvenience and additional cost to members and includes cost for insurance.

It may be so. It may also be a question

of choice for particular women.

Primary care -- and this is amended to add -- and specialty training programs should incorporate the full range of primary health needs of men and women and should prepare practitioners for design practitioner teams to provide for the totality of these needs.

MCOs should ensure that primary care practitioners or teams made available to members are capable of providing the full range of necessary primary care services to avoid duplication that is costly to both plans and members.

MCOs should be encouraged to require generalists who wish to provide primary care to women to demonstrate competency in basic aspects of gynecological care such as breast and pelvic exams, contraceptive management, and initial management of common gynecological problems.

We added here women should be allowed direct access to the reproductive health providers, either OB-GYN, nurse practitioners, or other advanced practice professionals who provide reproductive health care.

MR. ZATKIN: Could you read that again.

MS. RODRIGUEZ-TRIAS: Yes.

Women should be allowed direct access to their reproductive health providers be they OB-GYN, physicians, or nurse practitioners or other advanced

practice professionals. And that includes family practice, maybe PAs, who are qualified.

And plans should offer coverage for a full range of reproductive health services including fertility control; sexually transmitted diseases: prevention, detection, and treatment; modalities of family planning, methods and devices.

And, finally, collaboration between the public and private sector of consistent standards and development of evidence-based, gender-specific practice guidelines should be encouraged.

Go one by one?

CHAIRMAN ENTHOVEN: Discussion.

DR. NORTHWAY: You added some things that are not in the paper; is that correct?

DR. RODRIGUEZ-TRIAS: Yes. The last two. I'll repeat. The last two.

Before "collaboration" insert "women should be allowed direct access," and this was based on commentary and also on review and my own bias. Women should be allowed direct access to the reproductive health providers, either OB-GYN, nurse practitioners or other advanced practice professionals. Plans should offer coverage for a full range of reproductive health services including fertility control; sexually transmitted diseases: diagnosis -- prevention, diagnosis and treatment; and family planning information, education, and devices.

CHAIRMAN ENTHOVEN: Discussion. Take the first bullet.

DR. RODRIGUEZ-TRIAS: Do we need to read it again?

CHAIRMAN ENTHOVEN: No.

Tony.

MR. RODGERS: There is a dilemma with bullet one and bullet two in that, in one respect you're asking the plan to coordinate and integrate services, and in another respect you're saying but the woman should have the authority to go outside the plan to other sites of care for confidentiality purposes. And this has been a dilemma. How do you reconcile that?

DR. RODRIGUEZ-TRIAS: It is physical, but I don't think there is any perfect solution out there. But there are plans that actually have contracted with the traditional family planning providers and are paying on a service basis, on a service contract basis.

There are others that are partnering with some of the public health clinics that, again, traditionally are serving. And in some plans they appear as carve outs. So there are various modalities of dealing with this.

I think the important thing to me is that within plans they attempt to coordinate directly but that they do allow that choice for those who had -- in those communities had traditional providers that

they're perfectly content with. The issue of confidentiality is very, very fundamental and particularly for adolescents who may want to be off-site.

MR. ZATKIN: I didn't read that as providing for the right to go out of plan the way you write it. I read it to mean that plans should make -- try to make arrangements to accommodate the preferences of their enrollees and particularly if it looked like enrollees with (inaudible).

MR. RODGERS: The statement was not available within the plan, and I was curious --

MR. LEE: I think we're on to bullet two. Can we jump over bullet one and agree there are no objections and then talk about bullet two? No objections to bullet one?

MR. RODGERS: I just wanted to make sure there was consistency between bullet one and two.

MR. LEE: That's minor wordsmithing. But it's wordsmithing stuff that's not content on bullet one, but I'll get to it.

CHAIRMAN ENTHOVEN: We have no objection to one, then, I take it.

Two.

(Reviewing document.)

Services not available within the plan. Isn't the plan supposed to -- Barbara.

MS. DECKER: I must confess I don't

appreciate this to the extent I think probably Helen does. Within an HMO type organization, I don't see how we can expect the plan to make arrangements with local community-based clinics to provide certain kinds of primary care like this that normally is covered in the capitation.

It doesn't seem fair to the plan to be ready to pay out of plan for these things and/or to make arrangements that it's being available when the way the financing is working nowadays, it's -- the dollars go to a group that is supposed to be providing this range of services.

DR. RODRIGUEZ-TRIAS: I'm not familiar with a lot of range of arrangements, actually, and I'm sure around this table some other people are more familiar than I am. But there are some places where they have contracted with planned parenthood clinics, for instance, to provide -- to continue to provide the reproductive health care.

MS. DECKER: Okay.

CHAIRMAN ENTHOVEN: Peter. J.D.

DR. NORTHWAY: I'm not totally sure what the problem is here. Is it the confidentiality scheduling or is it they don't get -- or that the plan won't offer the services? I have a feeling it's the former, not necessarily the latter. And maybe we should be working on something to improve the former rather than to say -- the confidentiality in the

scheduling -- rather than to say because the plan can't keep these things confidential, you have to go outside the plan. Maybe I'm missing it.

DR. RODRIGUEZ-TRIAS: I think it's a historical basis for this. Very often the provider that women have been familiar with -- because what takes the most frequently, too, for medical care is related to reproductive health services. And that's somewhere where they have been going and are used to and have a preference for.

And in comes they're being enrolled in a managed care program which may or may not have equivalencies but there is a preference established. That is one way in which it happens.

Another in which it happens -- and this is particularly with young women -- is that they seek reproductive health services and really crave that confidentiality to be protected and bills, for instance, that get sent home when they're young women living at home and so on are a dead giveaway. So it's -- for them it's very important to have a health WIC even if sometimes they have to pay out of pocket. So it's an issue.

CHAIRMAN ENTHOVEN: Duffy.

DR. DUFFY: Are you including in this discussion the fact that you were at a Catholic hospital not for abortions so, therefore, the group that you're connected to wouldn't pay for an abortion,

you would have to go outside -- however you want to clean it up. I mean, I'm just being direct. That would be one aspect where you would have to go outside the plan in order to do so.

DR. RODRIGUEZ-TRIAS: Yes. That's a very good example of a restriction that would be within a plan, that would be not available. And it's not just necessarily abortions. It's happening with sterilizations and in some cases with even modalities of birth control.

DR. DUFFY: Or HIV or something of that nature which gets into your records.

MR. ZATKIN: It may not be available in the hospital. It is available in the plan.

DR. DUFFY: In your plan, but is it true in all plans?

CHAIRMAN ENTHOVEN: They have to do that.

Any other comments?

Without objection.

No. 3.

MR. WILLIAMS: The big issue on No. 3 is the plan finds himself, I think, in the middle on this issue and that in communicating, for example, to, you know, adolescents about services available, you know, what's the plan's role relevant to the parent's role, it gets to be a pretty sick issue for a health plan. I don't know what the answer is, but I'm capturing the issue -- that part of the issue.

CHAIRMAN ENTHOVEN: When I was a parent of teenage daughters, I wouldn't have appreciated it if the HMO wrote letters to them asking, "Where do you get your birth control?" I just hope we don't get that into a piece of legislation. It would be a real battle if it is.

Any objections with No. 3?

Should we move on to No. 4? Let's number that 4 and then the minor dots A and B. And --

DR. ROMERO: C and D.

CHAIRMAN ENTHOVEN: So 4A, primary care and specialty training programs should incorporate the full range of primary health needs of men and women and should prepare practitioners or -- practitioner teams to provide for the totality of these services.

DR. RODRIGUEZ-TRIAS: Objections?

CHAIRMAN ENTHOVEN: No objection?

DR. RODRIGUEZ-TRIAS: Inserting primary care and specialty care.

DR. SPURLOCK: I have one concern on this. I'm not quite sure, Helen, the purpose or intent of specialty training programs. It seems like there are a couple of issues going on. 99 percent of the physicians that go into specialty programs go through a primary care program either for one year or three or four years before they go into a specialty. Even surgeons go through general surgery, a primary program.

So I'm not sure that there's any added

benefit from specialists. I didn't study ophthalmology to know those things. I think if your spirit is we should be broad enough to understand all the diseases, how to relate to men and women and all cultures and all these demographics, I totally agree with that. If you think the specialist has to understand primary care issues in the training program, like reproductive issues for women, I'm not sure that's really appropriate.

DR. RODRIGUEZ-TRIAS: Bruce, I frankly wasn't thinking of ophthalmologists here in inserting "speciality." I was thinking more of internists, surgeons and all of whom are, you know, considered (inaudible) specialists. And there are some major issues, for instance, in the recognition of domestic violence, just to mention one that's fairly recent in our consciousness and in which there are great efforts made to train the people, staff in hospitals to recognize when a women presents as a possible victim of domestic violence, you know, that sort of training. Those who are likely to see women should know about the specific needs of women.

DR. SPURLOCK: We would be accomplishing the same thing by just striking "primary care." I would say, "Training programs should incorporate full range of primary health needs of men and women."

DR. RODRIGUEZ-TRIAS: Yes. I'll be quite happy with that.

MS. FARBER: Helen, it's already law in the State of California that the emergency room staffs in hospitals have to be trained and report victims of violent crime. And that's not only with respect to women that are abused by their husbands but also elder abuse and child abuse. And there is specialty training provided in all hospitals that provide basic emergency service or trauma service for their staff. So that's already in place.

DR. RODRIGUEZ-TRIAS: For emergency room?

MS. FARBER: Emergency room.

DR. RODRIGUEZ-TRIAS: Right. But not necessarily for all other physicians or health professionals.

MS. FARBER: That's true.

CHAIRMAN ENTHOVEN: I share Bruce's concern, not only ophthalmologists but interventional cardiologists and all kinds of other people that are -- and pathologists.

Helen, you wouldn't settle for just primary care?

DR. RODRIGUEZ-TRIAS: I said it was fine as Bruce suggested.

DR. SPURLOCK: Training programs.

DR. RODRIGUEZ-TRIAS: That or just training programs. And you can even add "as appropriate" if you wish. I'd be happy with that.

CHAIRMAN ENTHOVEN: Okay. "As

appropriate." Good.

DR. RODRIGUEZ-TRIAS: 5 or -- 4B.

CHAIRMAN ENTHOVEN: 4B. "MCOs should insure primary care practitioners" --

DR. SPURLOCK: A couple of points to make on this.

CHAIRMAN ENTHOVEN: Yes.

DR. SPURLOCK: Thank you, Mr. Chairman.

My issue primarily is -- it's twofold. One with the second sentence that says that managed care organizations should make sure that so and so can demonstrate competency. And I'm not sure that's the appropriate place because competency is a huge issue that requires a lot of multifacet aspects to it. And that it may be through the licensing and credentialing process of different agencies and organizations they demonstrate competency.

I think the spirit of your efforts is to say that general to provide primary care should be competent to be able to face this aspect of gynecologic care. I would also tag onto that that, if -- and we come down to your later recommendations -- OB-GYN docs assume primary care, they should be competent in primary care aspects.

I think the coin should flip the other way so that women choose gynecologists as their primary care docs. They should be competent in the broad range of primary care activities and should be able to

demonstrate that to whatever licensing or credentialing or crediting body requires that. I think that really gets to the spirit of what you're talking about without saying that the managed care organization needs to have that demonstration. I think it would be weird for me to see the -- showing a pelvic exam in front of a managed care organization. It would be hard for me to do that.

DR. RODRIGUEZ-TRIAS: I would accept that as a friendly amendment, to use "being competent in" or to -- however you amend it there, that's fine. Because I think you're right, competency does have a different implication.

But may I say that the law that was -- the bill that was passed into law in '94 actually does allow for choosing OB-GYN providers as primary care provided they have had training in primary care. That's already in the books. So you need the flip side of that.

CHAIRMAN ENTHOVEN: Okay. Any objection with that correction?

DR. ALPERT: It's verification that -- I think unless -- I don't want to put words in Helen's mouth, but I think what she's saying is what Bruce said already exists. It doesn't have to be here. And she just wants to put in the flip side. And the reason I don't think that is trivial is that, if you put Bruce's -- as I understand it, Bruce may want to

elaborate on this -- you put that back in, it makes it the same as the law, the law (inaudible) the impact it was because of the requirement of the gynecologist having to demonstrate this specialty training.

They haven't taken on this rubric of primary care and the women have not been able to choose them as direct access and then that defeats the purpose of what she's trying to do with her next recommendation which is to get direct access. So -- unless I'm just --

DR. RODRIGUEZ-TRIAS: There're two things. I think one thing is choosing the OB-GYN -- or the gyne -- let me use reproductive health professional or reproductive health provider because I did say nurse practitioners or other advanced practice people -- as the primary care person versus having direct access to that specialty when you need it.

DR. ALPERT: So you're saying your wording allows that leeway.

DR. RODRIGUEZ-TRIAS: I mean, you're symptomatic, you know, two months from having seen your primary care person and you want to go directly.

DR. ALPERT: Your wording no matter what it says is to provide them care?

DR. RODRIGUEZ-TRIAS: Right. It's not about their being primary care people. It's about women having the ability to access them directly.

CHAIRMAN ENTHOVEN: That's now Item C,

women should be allowed direct access to their reproductive health providers and M.D.'s, nurse practitioners, or other advanced practice professionals.

The discussion on that item.

Yes, Michael?

MR. SHAPIRO: I actually don't have a discussion, just a question. A lot of us haven't seen the language, you're about to pull the pin on two hand grenades, very controversial issues at the end of the day, where people haven't had any background developed on that.

I wondered if you might consider putting in the paper "subject to 16 votes," give us some background -- I know of at least two bills on this subject, one that's been vetoed and one that was withdrawn from the Governor to await the recommendations of this group.

What I'm very cautious of is if you encourage it, those bills do not necessarily get signed. If you require it, that's the mandate. So I think you need to carefully consider these issues. They are controversial. I'm concerned about five minutes left to do that.

CHAIRMAN ENTHOVEN: That's wise advice.

Bruce.

DR. SPURLOCK: I just have some language recommendations.

Helen, I want to say right upfront that I'm in total support of direct access. I wouldn't want to produce the choices to women to get that access from their primary care practitioner; so it should be "either/or" rather than "and" -- do you know what I'm saying? -- so that they can have direct access to their primary care provider if they choose and they can have direct access to their reproductive health specialist. So it allows them the choice. I did this with my patients, "You can see me or you can see a gynecologist."

I'd like to add on to that (inaudible) in the language when you come up with it, similar to what Michael said, is that any increase in the premium this recommendation entails should be passed through to risk-bearing entities responsible for that care.

In speaking with physician organizations that bear a risk, that will have to necessarily bear the cost of this. They actually have this going on right now with some health plans and some certain products, that they get 14 cents per member if that member chooses that direct access product.

I think that's the spirit of paying for what we're doing and giving it to risk-bearing entities. Because it probably will add to the cost of that. And as long as there is a payment for it, I'm in complete support with the choice provision.

CHAIRMAN ENTHOVEN: Dr. Duffy.

DR. DUFFY: This is a very key issue for women. I've been on national television twice on women's issues. I got briefed before going on by the senior female nurse here in Sacramento and also the senior chief of anesthesia. Their first comment was choice, choice of a GP to take care of their sore throats, so forth, or by a gynecologist. They're both in their early forties. And they were very, very concerned that people don't listen.

CHAIRMAN ENTHOVEN: Helen, my problem with it is going to be endorsing and bringing on the heavy hand of legislation into the delicate issues of coordination of medical care and in one fell swoop wiping out the whole concept of coordination, which is what the paper was about.

I think that the balance of which tasks are done by which doctor, you know, is a complex issue which depends on what they're trained on or not. And the paper has been saying for ordinary primary care gynecology, that primary care physicians ought to learn to do well-women exams, breast care, so forth, and that that would enable the health plans to have one visit take care of all the needs of the well women.

Now, if you turn around and contradict that in this one and say, "Oh, no, she should be able to go directly without even stopping by to check with the primary care doctor, then one thing it will probably do is destroy the incentive to go the other

way.

I think there at least needs to be some kind of coordination and some way that the woman enters into a plan and an understanding with the primary care doctor and the gynecologist to let the gynecologist and the primary care doctor work out together who's going to do what.

The thing I'm concerned about is that, you know, we sort of passed a law that just shreds the ability of the health plan to do coordination, and then when this one gets established and we've required the OB-GYN (inaudible), of course every other specialty is going to see that and we're going to create a great pork barrel or every specialty is going to want a direct access provision. And, you know, there goes the premiums, there goes the costs.

So it -- to me the idea of the Legislature starting -- getting in and passing laws like that is an attack on the part of managed care. Of course, if a woman needs a gynecologist or has some reason for a gynecologist, then she ought to be able to see her.

And it would be wise in many cases for the primary care doctor to work it out and say, "Okay, I work in partnership with this and that gynecologist -- and I have an open referral arrangement provided we have an understanding of when you go, for what reasons. I do these exams, she does those exams,"

et cetera.

But that's the thing. I just get a little worried about it. When you make a blanket statement like that, you are attacking the concept of the coordination of care, the heart of this.

DR. RODRIGUEZ-TRIAS: I can see myself as sort of blowing up the whole managed care system by this suggestion. It actually comes out, though, of consumer demand, Alain, and that's what I think we have to see. The laws are being driven by people saying to the legislators, you know, "Something is wrong here. This is what we want:

CHAIRMAN ENTHOVEN: Well, usually we look to the market and competing plans to be driven by consumer demand so that those who want economical care that is coordinated can choose it, those that want open access, no limits or anything else can have that also, but they pay for it.

Nancy.

MS. FARBER: I think most women between the age of about 14 when she start menstruating until about 50 or so when they go through menopause, most of their issues are around reproduction or preventing it or irregularities associated with it. And they want access to their OB-GYN. After 50 it becomes a very different issue. They're facing other life-threatening, potential, chronic disease issues.

But for the most part, young women and

mature women in their child-bearing years are well except for issues that relate to reproduction. And it's stupid to make them go see a primary care gatekeeper to give them permission to go to an OB-GYN every time they want to see an OB-GYN. And we end up paying for the care twice.

Now, if managed care is about reducing cost and being efficient, I think that people ought to recognize where women get their health care as a matter of choice and a matter of preference.

CHAIRMAN ENTHOVEN: Okay.

Alpert.

DR. ALPERT: As Nancy was alluding to, the complexities of reproductive physiology and the unparallel hormonal assault that accompanies that, that ultimately ends up producing cancer in three organs in obscene rates is unparallel. It's unique in human biology. It's not seen anywhere else.

And the idea of cost I think in creative ways could be dealt with, but simply pay the same thing you would have paid for whatever the visit was in either place and deal with that on the economic level. But don't sacrifice the uniqueness of this compelling medical issue. Women should be able to see gynecologists. I think every physician here that takes care of patients knows that from the history.

CHAIRMAN ENTHOVEN: Williams.

MR. WILLIAMS: I think that the issue

isn't what I said about should they or shouldn't they. I think clearly the market has spoken. I think, as described by Nancy and by Helen, that there is a strong interest in this. I think that the point that the Chairman was making is whether this is a manadate role and the micromanagement of it.

I know when I look at the market, most health plans have the ability for a woman at a minimum to see a reproductive specialist, even an OB-GYN, two or three times a year with no referral from the primary care physician. I think other health plans, ourselves included, are developing other products that provide much more open access.

I think it's where the market is demanding this and it's very clear what the market is interested in. And women may help a big part of the health care consuming market. Health plans will move in that direction.

MS. FINBERG: I think that this issue is fundamentally different from access to any other specialty. As Nancy indicated, women have been getting direct access to gynecology for years. And it's the only access to the health care system that they enjoy. If you require them to go first to a primary care physician, you're just duplicating their costs.

So I think it does differ from the other aspects of managing care and that it is true that most plans allow direct access now, recognizing that that's

appropriate. Those few that do not need to be directed that women need to make that choice.

I don't think that allowing gynecologists as primary care providers solves the problem. I don't want to go to a gynecologist for my pneumonia. I don't want to. And I want to be able to go directly to a gynecologist when I need a gynecologist and not go to a primary care physician.

DR. KARPF: Helen has "should," not "must." So I think we're really arguing over principles that we don't need to argue about at this point in time.

MR. LEE: That's part of what Michael's point is. We aren't having time to consider this. Maybe we can carry this over as --

DR. RODRIGUEZ-TRIAS: I think Michael's point is well taken.

MR. LEE: -- needing 16 votes to be a recommendation and we discuss it when we've got more than 12 of us here.

CHAIRMAN ENTHOVEN: We have several members of the general public who wish to testify.

DR. RODRIGUEZ-TRIAS: I have one more recommendation before we go on to that. There was another recommendation. We don't have time to take it up, I realize. It's a complex one that will need sufficient time for discussion; so I guess we just have to leave it on the table.

MS. FINBERG: That will be in the paper for the next round?

DR. RODRIGUEZ-TRIAS: Yes. We'll number these as --

CHAIRMAN ENTHOVEN: We'll identify it as still open questions.

Yes, Michael.

DR. KARPF: Mr. Chairman, I think we've made incredible progress over a three-day period of time. I would hope that we can be very expeditious in voting when we get back in December. I also had hoped that we would be able to save some time to review sort of the broad strokes of what we've accomplished, kind of make sure it all fits together, that there aren't holes that we've left. So whatever it takes to kind of keep an open agenda, I'd like to propose that.

CHAIRMAN ENTHOVEN: I'm all for it, Michael, if we can just keep people moving through this.

DR. KARPF: I may be too optimistic, but I actually think that the voting process should go relatively quickly.

CHAIRMAN ENTHOVEN: We are going to hear from members of the general public. Clark Kerr has kindly agreed to replace me as chairman so that I can meet my departure requirements.

VICE CHAIRMAN KERR: The first person is Maureen.

MS. O'HAREN: Thank you, Mr. Chairman. I'll try to be brief. I know you all want to get going. I think our first concern is with Recommendation No. 2, if that -- if the intent of that recommendation is that plans must allow people to go out of network.

We are required by law to provide all medically necessary services within the plans. We're also required by law to abide by the confidentiality laws and to provide for after-hours care. So this recommendation is really unnecessary within the confines of this issue.

The third recommendation regarding encouraging plans to provide information directly to all plan enrollees could be a costly mandate. If you're talking about sending four, you know, quarterly newsletters, for example, to a family where you have two parents and two children, there is no reason to send four copies of a newsletter, which could be very expensive mailing.

So we don't think this should be a blanket recommendation. Certainly there are certain -- for example, I think COBRA requires that certain information is supplied to all enrollees. And that's appropriate because of the COBRA laws.

Regarding the recommendation that all women should be allowed direct access to OB-GYNs -- I think it has been discussed -- the market has

responded. We did a survey of our membership in response to the Susan Davis bill and found that, of the 15.2 million people currently enrolled in HMOs, 93 percent are covered by an HMO that offers at least one well-woman visit annually, which is a direct access self-referral visit.

And the major barrier to unlimited access is at the provider group level. You don't have an integrated provider (inaudible) medical group, for example. It's very hard to provide that access in a way that allows you to continue to coordinate care.

So, for example, the Permanente medical groups and the larger medical groups -- they can do this very easily. Some of the other smaller groups cannot. In terms of capitated it's a problem in terms of making sure that the care is provided and paid for.

The last -- I also echo the concern that this is a precedent leading to more direct access to specialists. I'm sure that, while women have concerns about reproductive care, there is also the issue of men over 50 who want direct access to cardiologists, et cetera, et cetera. I would like direct access to an orthopedist once in a while or a chiropractor.

The last issue in terms of plans should be required to cover a full range of reproductive care, that is already required. Knox-Keene plans are already required to provide a variety of voluntary family planning services so that we see that as redundant or

at least that should be acknowledged in this paper in terms of what the law is.

Thank you.

MS. DECKER: The 93 percent -- could you say the stat again, please.

MS. O'HAREN: Statistically, 93 percent of the individuals currently enrolled in health care service plans in the state are enrolled in a plan that at the very least provides a once-a-year direct access well-woman visit. Some of the plans included in that number provide unlimited access.

MS. FINBERG: How many plans don't allow direct access?

MS. O'HARE: Oh. I forgot to mention that. Most, if not all, of the plans that don't provide direct access, most of them are smaller Medi-Cal only plans. Medi-Cal plans, as you know, are required by the law to cover services outside of network, inside of network, for any family planning service.

So, for example, even if you don't contract with the planned parenthood clinic, a Medi-Cal member can go there. So they will receive their annual pap, for example. They will get that care outside. So we feel that those members are taken care of in terms of their choice of provider.

MS. FINBERG: You don't have a number on -- the number of plans involved?

MS. O'HAREN: I think there were 10 plans total that did not. I can provide you the data.

MS. FINBERG: Federal law and state Medi-Cal law requires that they not be treated any differently than anybody else. So I don't think it's (inaudible) --

MS. O'HAREN: Well, the individual plans do not treat their members any differently. For example, if there's a Medi-Cal member enrolled in Kaiser, they get the same direct access as any other member of Kaiser, but you have some smaller Medi-Cal plans that do not provide for direct access. It's across the board. All of their members get the same treatment.

VICE-CHAIRMAN KERR: Any other questions?

Thank you, Maureen.

VICE-CHAIRMAN KERR: Betty Perry, Older Women's League.

MS. PERRY: I'm Betty Perry. I'm the education and research coordinator for the Older Women's League of California. I think I've written all of you.

The Older Women's League appreciates your specifically addressing the health needs of women. We believe the background information which the report conveys makes it imperative that special attention be given to these needs. We realize the industry must be cost-effective.

But my experience and your report confirms that women have the tendency to underutilize services for all the reasons you gave. In the long run I believe there is a great need to make health services more available to women, not less available. This, I believe, will be far more beneficial and more cost-effective than if women secure inadequate preventive care.

We question the recommendations. The recommendations do not mention any way to deal with the mental health needs of women, needs the report described very well. Until this afternoon, I wondered why there was no mention of the need for plans to make payment for contraceptives, but I think the changes in the report indicated concern about that. We're also concerned about the absence of specific recommendations about other procedures which are particular problems of women's health.

And I'd like to say we admire the feeling of respect that is developed among the Task Force members, and we look forward to a very good report.

VICE CHAIRMAN KERR: Thank you.

Questions?

Jim Randlett, California Association of Obstetricians and Gynecologists.

MR. RANDLETT: My name is Jim Randlett. I'm with the California Association of Obstetricians and Gynecologists. I'm a legislative advocate and bear

some responsibility of bringing the subject to you as a sponsor of the Susan Davis legislation. We have before you our correspondence on this matter, and I won't attempt to repeat that. I believe Miss Davis has written all the members as well.

Just a couple of points. Miss O'Haren has very skillfully, as always, presented some facts to the situation, but this is a red herring that she is dragging across the trail. Unless you attempted to send this red herring and go down the wrong track, I would point out to you that her 93 percent figure is that annual, once-a-year, well visit to the family physician.

So she would have you to accept that 93 percent figure. She would have you think that this is the direct access. This is not by any stretch of the imagination direct access to an OB-GYN. We find as best we can, because it's a very complicated matter, that roughly 50 percent of the women in California have true direct access to an OB-GYN. And that's where two months after your annual well visit you have an abdominal pain, you would naturally want to go to your OB-GYN.

In the situation where 50 percent of the women in the state right now that are in HMOs, they would have to call a gatekeeper, get on the gatekeeper's schedule, and then if the gatekeeper gave them permission, then they would be referred to the

OB-GYN. We think that's a rather sad state of affairs.

Inherent in that, we have the financial incentive, unfortunately some primary care physicians are suspect to, that would allow them to keep the patient, say, "Well, try this, try this, and I'll see if I can work it out, then I'll make you a referral." For these reasons direct access is needed.

Also on the coordination issue that was brought up, the direct access is to an OB-GYN that is in the plan. It's not somebody outside the plan. So this is all part of that health plan's family, if you will.

So the -- we entertain the legislation requirement as long as it wasn't a prior authorization requirement that that OB-GYN contact the family physician, primary care physician when they receive the patient under direct access. Therefore, that allows direct coordination. We think that is important, worthwhile and something that could be included in the legislation for the policy of this Task Force.

And then, finally, as far as the precedent goes, I think you spoke to that. This wouldn't be a question of (inaudible), orthopedic surgery, or something like this. You've heard, the materials that you have, 75 percent of the women in the United States between the ages of 14 to 45 see their OB-GYN primary care physician. No other specialty has that. For these reasons, we would ask you to include

in your recommendations that direct access be provided for.

VICE CHAIRMAN KERR: Questions?

DR. SPURLOCK: You mentioned something about incentives for primary care doctors not necessarily providing the highest quality of care. Do you --

MR. RANDLETT: No. Referral, not -- but they're not well trained and they're not trained in that specialty. But I didn't say that there was an incentive that they would provide other than highest quality.

DR. SPURLOCK: Are you saying you have data to suggest there's a quality difference on (inaudible), reproductive issues? Is there anything in the report that primary care is not accurately doing that?

MR. RANDLETT: I believe that an OB-GYN is better qualified than a family practitioner. They have a three-year residency specialty.

VICE CHAIRMAN KERR: Any other questions for Jeff?

Thank you very much.

Any business anybody wants to bring up?

Obviously not. I declare the meeting adjourned.

(Meeting adjourned at 5:15 p.m.)

STATE OF CALIFORNIA)
)
COUNTY OF LOS ANGELES)

I, GEORGETTE L. URBANO, CSR 8747, for the State of California, do hereby certify:

That said hearing was taken before me at the time and place therein set forth and was taken down by me in shorthand and thereafter transcribed into typewriting under my direction and supervision;

That said hearing is a true record of the testimony given.

I further certify that I am neither counsel for nor related to any party to said action nor in anywise interested in the outcome thereof.

EXECUTED this day of , 1997.

Georgette L. Urbano, CSR, RPR